

**ATTACHMENT A
A01 PERFORMANCE CONTRACT NOTEBOOK (PCN)**

CONTRACTOR:

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SECTION I. STATEMENT OF WORK

A. Authority and Administrative Services

1. Local Planning

Contractor is the designated Local Mental Health authority (LMHA) for the Local Service Area (LSA). As the LMHA, Contractor is required to:

- a) Maintain, update, and implement a Consolidated Local Service Plan (CLSP) in accordance with Information Item I.
- b) Involve community stakeholders in developing the CLSP, monitoring its implementation, and updating as needed. At a minimum, the LMHA shall invite the stakeholder groups identified in Information Item I.
- c) Maintain, update, and implement a Local Provider Network Development Plan (LPND Plan) in accordance with Information Item I.
- d) Comply with 25 Texas Administrative Code (TAC) Chapter 412, Subchapter P (Provider Network Development) and applicable DSHS directives related to the development and implementation of the Provider Network Development Plan.
- e) Submit the CLSP and the LPND Plan to DSHS according to the Submission Calendar in Information Item S.
- f) Maintain a current version of the CLSP and the LPND Plan on the LMHA's website, with revision dates noted as appropriate for each plan revision.
- g) Annually post on the LMHA's website a list of persons with whom the local authority had a contract or agreement related to the provision of mental health services, except for peer providers and Family Partners as defined under Family Partner Supports in Information Item G of the Performance Contract. The list shall include the number of peer support and Family Partner contracts and agreements, but not the names of the peer support or Family Partner providers without their written consent. The list shall include all contracts or agreements in effect during all or part of the previous year, or on the date the list is posted. Family Partners hired or contracted must meet the following qualifications:
 - (1) Is 18 years of age or older;
 - (2) Has received:
 - (a) A high school diploma; or
 - (b) A high school equivalency certificate issued in accordance with the laws applicable to the issuing agency;
 - (3) Has at least one year of experience raising a child or adolescent with an emotional or mental health issue as a parent or Legally Authorized Representative (LAR);
Has at least one year of experience navigating a child-serving system (e.g. mental

health, juvenile justice, social security, or special education) as a parent or LAR;
and

- (4) Has ability to perform the duties of a Family Partner as outlined in the Texas Resilience and Recovery Utilization Management (UM) Guidelines.
- (5) Each Family Partner must have successfully completed the certified family partner training and passed the certification exam recognized by the department within one year of the date of hire for the role of Family Partner.

Additional information on peer resources can be found at
<http://www.dshs.state.tx.us/mhsa/mh-adult-services/>.

- h) Maintain a toll free phone number for routine services and for crisis services posted on the contractor's website and on any other advertising documents used.
- i) An individual must answer the phone during regular business hours.
- j) DSHS-funded providers must not deny access to services at any level solely based on age, race, religion, gender, sexual orientation, substance use or abuse, or disability including chronic illness and medical conditions, including pregnancy or HIV.
- k) Through its local board, appoint, charge and support one or more Planning and Network Advisory Committees (PNACs) necessary to perform the committee's advisory functions, as follows:
 - (1) The PNAC shall be composed of at least nine members, 50 percent of whom shall be clients or family members of clients, including family members of children or youth, or another composition approved by DSHS;
 - (2) PNAC members shall be objective and avoid even the appearance of conflicts of interest in performing the responsibilities of the committee;
 - (3) Contractor shall establish outcomes and reporting requirements for each PNAC;
 - (4) Contractor shall ensure all PNAC members receive initial and ongoing training and information necessary to achieve expected outcomes. Contractor shall ensure that the PNAC receives training and information related to 25 TAC Chapter 412, Subchapter P (Provider Network Development) and that the PNAC is actively involved in the development of the Consolidated Local Service Plan and the Provider Network Development Plan;
 - (5) Contractor shall ensure the PNAC has access to all information regarding total funds available through this Scope of Work for services in each program area and required performance targets and outcomes;
 - (6) Contractor shall ensure the PNAC receives a written copy of the final annual budget and biennial plan for each program area as approved by Contractor's Board of Trustees, and a written explanation of any variance from the PNAC's recommendations;
 - (7) Contractor shall ensure that the PNAC has access to and reports to Contractor's Board of Trustees at least quarterly on issues related to: the needs and priorities of the LSA; implementation of plans and contracts; and the PNAC's actions that respond to special assignments given to the PNAC by the local board;
 - (8) Contractor may develop alliances with other LMHAs to form regional PNACs;

(9) Contractor may develop a combined mental health and intellectual and developmental disability (IDD) PNAC. If Contractor develops such a PNAC, the 50 percent client and family member representation shall consist of equal numbers of mental health and IDD clients and family members. Expanded membership may be necessary to ensure equal representation.

2. Policy Development and Management

Contractor shall develop, implement, and update policies and procedures to address the needs of the LSA in accordance with state and federal laws and the requirements of this Scope of Work. Policies shall include consideration of public input, best value and client care issues.

3. Coordination of Service System with Community and DSHS

Contractor shall:

- a) Adhere to DSHS directives related to Client Benefits Plan as described in Information Item H.
- b) Ensure coordination of services within the LSA. Such coordination shall ensure collaboration with other agencies, including local hospitals, nursing facilities, other health and human service agencies, criminal justices entities, Substance Abuse Community Coalition Programs, Prevention Resource Centers, Outreach Screening Assessment and Referral organizations, other child-serving agencies (e.g., Texas Education Agency (TEA), Department of Family and Protective Services (DFPS), Texas Juvenile Justice Department (TJJD), family advocacy organizations, local businesses, and community organizations). Evidence of the coordination of services shall be maintained. Evidence may include memorandums of agreement, memorandums of understanding, sign-in sheets from community strategic planning activities, or sign-in sheets from community-based focus group meetings.
- c) In accordance with applicable rules, ensure that services are coordinated:
 - (1) Among network providers; and
 - (2) Between network providers and other persons or entities necessary to establish and maintain continuity of services.
- d) Designate a physician to act as the Medical Director and participate in medical leadership activities. Submit this staff person's contact information as part of Form S.
- e) Ensure client has an appointment scheduled with a physician or designee authorized by law to prescribe needed medications, if the Continuing Care Plan, as defined in 25 TAC Chapter 412, Subchapter D, Mental Health Services – Admission, Continuity, and Discharge, indicates that the LMHA is responsible for providing or paying for psychotropic medications.
- f) The appointment shall be on a date prior to the earlier of the following events:
 - (1) The exhaustion of the client's supply of medications; or

- (2) The expiration of 14 days from the client's discharge or furlough from a State Mental Health Facility (SMHF).
- g) Provide individuals a choice of qualified physicians or designees authorized by law to prescribe needed medications through face-to-face encounters or via tele-medicine to the maximum extent possible. This shall be accomplished by the following, listed in order of priority:
- (1) Employing a qualified physician or designee authorized by law to prescribe needed medications; or
 - (2) Contracting with a qualified physician or designee authorized by law to prescribe needed medications; or
 - (3) Notifying DSHS within one business day if both employing and contracting with a qualified physician or designee authorized by law to prescribe needed medications is not possible for any period of time during the contract period. Planned efforts shall be documented and submitted to DSHS by contractor who shall seek technical assistance from DSHS if this situation persists for 5 consecutive business days within the contract period. All efforts shall be continued and documented and the contractor shall provide choice to individuals as outlined below until the situation has been remedied:
 - (4) Referring the individual to a qualified physician or designee authorized by law to prescribe needed medications who is not employed or contracted by the contractor but is within 75 miles of the individual's residence; or
 - (5) If the contractor lacks the capacity to meet any of the above requirements, contractor shall identify the nearest available non-local (more than 75 miles from the individual's residence) qualified physician or designee authorized by law to prescribe needed medications. If the individual indicates the distance to the provider is not a barrier to accessing services, then Contractor shall refer the individual to the available service provider. Contractor shall document the discussion with the individual and the individual's decision regarding traveling to the non-local provider. If the individual indicates that the distance to the non-local qualified physician or designee authorized by law to prescribe needed medications is a barrier to accessing services, Contractor shall document a strategy to establish access to a provider.
- h) Provide clients a choice among all eligible network providers in accordance with 25 TAC, Chapter 412, Subchapter P (Provider Network Development).
- i) Offer each Level of Care (LOC) as outlined in the Texas Resilience and Recovery (TRR) Utilization Management Guidelines and provide the core services available within each LOC to individuals through face-to-face encounters or via tele-medicine/tele-health. This shall be accomplished by the following, listed in order of precedence:
- (1) Employing staff who meet the qualifications (i.e. licensure, training, and/or competency) to provide the core service; or
 - (2) Contracting with providers who meet the qualifications (i.e. licensure, training, and/or competency) to provide the core service; or

- (3) Notifying DSHS immediately if neither employing nor contracting with a qualified provider is possible for fifteen consecutive days during the contract term. This notification shall include the contractor's plan to resolve the unavailability of services. All efforts shall be continued and documented and the contractor shall provide choice to individuals as outlined in (4) and (5) below until the situation has been remedied:
 - (4) Referring the individual to a qualified provider who is not employed or contracted by the contractor but is within 75 miles of the individual's residence; or
 - (5) If the contractor lacks the capacity to meet any of the above requirements, contractor shall identify the nearest available non-local (more than 75 miles from the individual's residence) qualified provider. If the individual indicates the distance to the provider is not a barrier to the individual accessing services, then Contractor shall refer the individual to the available service provider. Contractor shall document the discussion with the individual and the individual's decision regarding traveling to the non-local provider. If the individual identifies that the distance to the non-local qualified provider is a barrier to accessing services, Contractor shall document a strategy to establish access to the core service.
- j) Develop an adequate provider network for the provision of the YES Waiver Service Array as outlined in the YES Waiver Policy and Procedure Manual to individuals through face-to-face encounters. This shall be accomplished by the following:
- (1) Contracting with qualified providers of the YES Waiver service array;
 - (2) Services on the IPC are provided free of conflict of interest and not by an individual developing the IPC or by the entity with direct oversight of the individual developing the IPC , except as the provider of last resort;
 - (3) Providing access to all services on an approved IPC within 10 business days of IPC approval, or later at the child/LAR request;
 - (4) Providing client choice among qualified providers of individual services; and
 - (5) Providing access to qualified providers within 30 miles of the client's residence.
 - (6) As the provider of last resort, serving as a comprehensive YES provider for the local service area in the absence of alternate qualified comprehensive providers contracted through the Department of State Health Services that have demonstrated sufficient capacity.
- k) Operate a continuity of care and services program for offenders with mental impairments, in compliance with Texas Health & Safety Code Chapter 614, and the guidelines outlined in Information Item T. Contractor shall:
- (1) Assist Community Supervision and Corrections Department (CSCD) personnel with the coordination of supervision for offenders who are LMHA clients. This shall include:
 - (a) Providing the local CSCD(s) with the name(s) of LMHA personnel who will serve as the contact(s) for continuity of care and services program referrals from the local CSCD(s);
 - (b) Participating in joint staffing related to offenders who are LMHA clients in order to review compliance with treatment and supervision;
 - (c) Providing input on modifications of supervision conditions;

- (d) Coordinating with CSCD personnel on imposing new conditions, sanctions and/or a motion to revoke/adjudicate in order to explore all possible alternatives to incarceration;
 - (e) Coordinating on the development of a joint supervision and treatment plan if governing standards for the respective participants can be adhered to in the proposed plan; and
 - (f) Participating in quarterly meetings with the CSCD Director(s) or her/his designee to review the implementation of activities related to the coordination of supervision.
- (2) Offer and provide technical assistance and training to the CSCD and other criminal justice entities (pre-trial, jail, courts) on mental health and related issues;
 - (3) Assist criminal justice and judicial agencies with the identification, and diversion of offenders who have a history of state mental health care through a local continuity of care and services program.
 - (4) Review available records of each incarcerated individual who has been formally determined to be Incompetent to Stand Trial and assist criminal justice and judicial agencies with diversion of offenders through a local continuity of care and services program. Complete Form Z, Forensic Clearinghouse Waitlist Template, following submission guidelines in DSHS Submission Calendar.
- l) Provide services to clients referred by the Texas Juvenile Justice Department pursuant to Title 37, Part 11, Chapter 380, Subchapter B, Division 2, Rule §380.8779.
- m) Identify and document clients who have been court-ordered to receive outpatient mental health treatment pursuant to Senate Bill 646 and the Texas Health and Safety Code Chapter 574. The following data is to be tracked locally, and submitted on Form W, until DSHS information technology system provides the capability to track it electronically:
- (1) Client CARE ID
 - (2) The date the court order was signed for outpatient mental health treatment.
 - (3) The date the individual began outpatient mental health treatment under the court order.
 - (4) Commitment type for outpatient mental health treatment (i.e. temporary or extended).
 - (5) The date the court order was signed to terminate outpatient mental health treatment.
 - (6) Total number of persons on a temporary court-order for mental health treatment.
 - (7) Total number of persons on an extended court-order for mental health treatment.
 - (8) Total number of persons transitioned from a temporary to an extended court-order for outpatient treatment.

Contractor shall track clients court-ordered to receive outpatient mental health treatment under the Texas Health and Safety Code, Chapter 574, pursuant to Senate Bill 646, beginning 09/01/2013. Each LMHA must identify a point of contact who is responsible for the identification and data collection of these clients.

- n) Participate in Community Resource Coordination Groups (CRCGs) for children, youth, and adults in the LSA by providing one or more representatives to each CRCG with expertise in mental health, authority to contribute to decisions and recommendations of the CRCG, and with authority to contribute resources toward resolving problems of individuals needing agency services identified by the CRCG. Participation is required by Texas Government Code §531.055, and duties shall be performed in accordance with Information Item M (Memorandum of Understanding for Coordinated Services to Persons Needing Services from More Than One Agency, revised March 2006).
- o) Cooperate with TEA in individual transition planning for child, youth, and adult clients receiving special education services, in accordance with 34 CFR part 300 (Assistance to States for the Education of Children with Disabilities).
- p) Establish and maintain a continuum of care for children transitioning from the Early Childhood Intervention (ECI) program into children's mental health services described in the Children's Services Attachment, including making best efforts to:
 - (1) Respond to referrals from ECI programs;
 - (2) Verify eligibility for mental health services;
 - (3) Inform the family about the available mental health services, service charges, and funding options such as Medicaid and Children's Health Insurance Program (CHIP);
 - (4) Participate in transition planning no later than 90 days prior to the child's third birthday;
 - (5) Assist in the development of a written transition plan to ensure continuity of care;
 - (6) Support joint training and technical assistance plans to enhance the skills and knowledge base of providers; and
 - (7) Submit local agency disputes that are not resolved in a reasonable time period (i.e., not to exceed 45 days unless the involved parties agree otherwise) to the ECI or DSHS Mental Health Program Services Unit for resolution at the state level.
- q) Designate a staff member to act as Contractor's Suicide Prevention Coordinator, and submit as part of Form S, this staff member's contact information. Contractor's Suicide Prevention Coordinator shall work collaboratively with local staff, LMHA suicide prevention staff statewide, and DSHS's Suicide Prevention Office to reduce suicide deaths and attempts by:
 - (1) Developing a collaborative relationship with any existing local suicide prevention coalition;
 - (2) Participating in Suicide Prevention Coordinator conference calls scheduled and facilitated by DSHS Suicide Prevention Officer;
 - (3) Participating in the development of the local Community Suicide Postvention Protocols as described by the Center for Disease Control Postvention Guideline;
 - (4) Participating in the implementation of the local Community Suicide Postvention Protocols when indicated, including contacting the DSHS Suicide Prevention Officer via email to Suicide.Prevention@dshs.state.tx.us of any youth suicide deaths contributing to a possible suicide cluster or contagion;

- (5) Completing Form Y, Organizational Readiness Assessment for Suicide Safe Care/ Zero Suicide, according to the instructions on the form and the due date on the Submission Calendar; and
 - (6) Participating in local community suicide prevention efforts.
- r) Ensure access to routine care by:
- (1) Providing access to care to individuals seeking services regardless of ability to pay;
 - (2) Providing access to a screening conducted by a Qualified Mental Health Professional - Community Services (QMHP-CS) to individuals presenting for routine care services, regardless of an individual having proof of personal information and funding source information;
 - (3) Demonstrating efforts to collaborate with other health care agencies and community resources to address the physical and behavioral health care needs of individuals, as well as ensuring that these needs are met;
 - (4) Ensuring the availability of a telephone system and call center that allows individuals to contact the LMHA through a toll-free number that must:
 - (a) Operate without using telephone answering equipment at least on business days during normal business hours, except on national holidays, due to uncontrollable interruption of service, or with prior approval of the department;
 - (b) Have sufficient staff to operate efficiently;
 - (c) Collect, document, and store detailed information, on all telephone inquiries and calls;
 - (d) Provide electronic call answering methods that include an outgoing message providing the crisis hotline telephone number, in languages relevant to the service area, for callers to leave a message outside of normal business hours, and
 - (e) Return routine calls before the end of the next business day for all messages left during and after hours.
- s) Contractor shall follow and adhere to the referral process for the Home and Community Based Services-Adult Mental Health (HCBS-AMH) program for individuals residing in the community that meet initial eligibility criteria for HCBS-AMH. Comprehensive instructions to complete the referral process can be found: <https://www.dshs.state.tx.us/mhsa/hcbs-amh/Community-Referral-and-Enrollment-Process.doc>. Contractor shall:
- (1) Review the MBOW Long Stay 1915i report located in the CA Continuity of Care folder;
 - (2) Designate a point of contact (POC) to coordinate HCBS-AMH referral process for individuals residing in the community;
 - (3) Coordinate with state hospital staff, as necessary, for individuals referred to the program who are currently in the state hospital;

- (4) Complete the HCBS-AMH Referral Form for individuals on the MBOW Long Stay 1915i or who otherwise meet referral criteria who are currently in the community; verify CARE ID of the referred individual; and submit the completed form via e-mail to HCBS-AMH@dshs.state.tx.us with the subject line titled “Referral;”
 - (5) Assist the referred individual and/or LAR, if applicable in completing the HCBS-AMH Consent for Eligibility Determination Form and submit consent form via e-mail to HCBS-AMH@dshs.state.tx.us with the subject line titled “Consent for Eligibility Determination”;
 - (6) Assist DSHS in coordinating the date and location of the HCBS-AMH assessment for the referred individual, if applicable; and
 - (7) Participate in the individual’s HCBS-AMH recovery plan meetings, including coordination with the individual’s HCBS-AMH recovery manager.
4. Resource Development and Management
- Contractor shall:
- a) Identify and create opportunities, including grant development, to make additional resources available to the LSA.
 - b) Optimize earned revenues and maximize dollars available to provide services, which shall include implementing strategies to minimize overhead and administrative costs and achieve purchasing efficiencies. Strategies that an LMHA shall consider in achieving this objective include joint efforts with other local authorities on planning, administrative, purchasing and procurement, other authority functions, and service delivery activities.
 - c) Assemble and maintain a network of service providers and serve as a provider of services as set forth in 25 TAC, Chapter 412, Subchapter P (Provider Network Development). In assembling the network, the LMHA shall seek to offer clients a choice of qualified providers to the maximum extent possible.
 - d) Submit required information via a post-procurement report to DSHS within 30 days of completing a procurement described in the LMHA’s approved Local Network Development Plan. DSHS will disseminate the post-procurement report template through a broadcast message.
 - e) Award new subcontracts in accordance with applicable laws and 25 TAC Chapter 412, Subchapter B (Contracts Management for Local Authorities) and Subchapter P (Provider Network Development).
 - f) Pay external providers a fair and reasonable rate in relation to the local prevailing market.

- g) Ensure providers are informed of and in compliance with the applicable terms and conditions of this Scope of Work by developing provider contracts which include the Scope of Work requirements.
- h) Implement network management practices to promote the effectiveness and stability of the provider network, including a credentialing and re-credentialing process that requires external providers to meet the same professional qualifications as internal providers.
- i) Implement a provider relations process to provide the support and resources necessary for maintaining an available and appropriate provider network that meets DSHS standards, including:
 - (1) Distributing information to providers on an ongoing basis to inform them of DSHS requirements;
 - (2) Informing providers of available training and other resources;
 - (3) Interpreting contract provisions and clarifying policies and procedures;
 - (4) Assisting providers in accessing the information or department they need;
 - (5) Resolving payment and other operational issues; and
 - (6) Resolving provider grievances and disputes.
- j) Ensure the providers are monitored and contracts are enforced in accordance with applicable laws and 25 TAC Chapter 412, Subchapter B.

5. Resource Allocation and Management

Contractor shall:

- a) Maintain an administrative and fiscal structure that separates local authority and provider functions.
- b) Maintain a Utilization Management (UM) Committee that includes the following Contractor staff:
 - (1) The UM physician;
 - (2) UM staff representative;
 - (3) Quality management staff representative; and
 - (4) Fiscal/financial services staff representative.
- c) Ensure that UM complies with the following for each position listed:
 - (1) A qualified UM physician who:
 - (a) Is a board eligible or board certified psychiatrist;
 - (b) Is licensed to practice medicine in the State of Texas; and
 - (c) Provides oversight of the UM program's design and implementation.
 - (2) A qualified utilization manager who is licensed to practice in the State of Texas as:
 - (a) Registered nurse or a registered nurse-advance practice nurse;
 - (b) Physician assistant;
 - (c) Licensed clinical social worker;
 - (d) Licensed professional counselor;

- (e) Licensed doctoral level psychologist; or
 - (f) Licensed marriage and family therapist.
 - (3) Has a minimum of five years' experience in direct care of individuals with a serious mental illness and/or children and youth with serious emotional disturbances, which may include experience in an acute care or crisis setting;
 - (4) Has a demonstrated understanding of psychopharmacology and medical/psychiatric comorbidity through training and/or experience;
 - (5) Has one year experience in program oversight of mental health care services; and
 - (6) Has demonstrated competence in performing UM and review activities.
- d) If Contractor delegates UM activities to other staff the following requirements shall be met:
- (1) The UM Director must:
 - (a) Be licensed to practice in the State of Texas as a:
 - i. Registered nurse or a registered nurse-advance practice nurse;
 - ii. Physician assistant;
 - iii. Licensed clinical social worker;
 - iv. Licensed professional counselor;
 - v. Licensed doctoral level psychologist; or
 - vi. Licensed marriage and family therapist.
 - (b) Have a minimum of three years' experience in the treatment of individuals with mental illness or chemical dependency; or
 - (c) If the UM Director is not licensed, she/he can oversee the UM Program administratively but not clinically. Clinical oversight must be conducted by an LPHA.
 - (2) A Utilization Reviewer or Utilization Care Manager, who is a Qualified Mental Health Professional Community Services (QMHP-CS), shall have at least three years' of experience in direct care for adults with serious mental illness or children and youth with serious emotional disturbances, and directly supervised by a qualified utilization manager.
- e) Ensure that UM job functions are included in each UM staff member's job description and documentation of licenses, training, and supervision maintained in the staff member's signed and approved personnel record.
- f) Ensure that the UM Committee meets at least quarterly to ensure effective management of clinical resources, fiscal resources, and the efficiency and ongoing improvement of the UM process. Contractor shall ensure and document that members of the UM Committee receive appropriate training to fulfill the responsibilities of the committee. Training is needed when a new member is added to the committee and as needed, at least annually, for the entire committee. Documentation of training contents may be included in committee minutes. The committee shall review:
- (1) Appropriateness of eligibility determinations;
 - (2) Use of exceptions and overrides to service authorization ensuring rationale is clinically appropriate and documented in the administrative and clinical record;

- (3) Over- and under-utilization;
 - (4) Appeals and denials;
 - (5) Fairness and equity; and
 - (6) Cost-effectiveness of all services provided.
- g) Implement a UM Program using DSHS's approved Texas Resilience and Recovery Utilization Management Guidelines that includes documented and approved processes and procedures for:
- (1) Authorization and reauthorization of LOC for outpatient services;
 - (2) Authorization of inpatient admissions to state hospitals and to community psychiatric hospitals and reauthorization for continued stay when general revenue allocation or local match funding is being used for all or part of that hospitalization;
 - (3) Verification and documentation that services provided are medically necessary;
 - (4) The role for UM in ensuring continuity and coordination of services among multiple mental health community service providers;
 - (5) A timely authorization system designed to ensure medically necessary services are delivered without delay and after requested services have been authorized (backdating of authorizations is not permissible). Crisis services do not require prior authorization; however, the authorization shall be completed within two business days after the provision of the crisis intervention service;
 - (6) Automatic authorization processes shall be based on a documented agreement with providers that only allows automatic authorization if the LOC recommended is the same as the LOC to be authorized, and only with providers who have documented competence in assessment using the Uniform Assessment (UA);
 - (7) Timely notification of clients and providers of the authorization determinations;
 - (8) A timely and objective appeal process in accordance with 25 TAC §401.464 and for Medicaid recipients, in accordance with 25 TAC §412.313(b) (2) (c), and Information Item Q procedures to give notice of fair hearings; and
 - (9) Maintaining documentation on appeals.
- h) Each biennium, review and update the quality management plan that includes the UM Program Plan and ensure that the plan includes a description of:
- (1) Requirements relating to the UM Committee credentials, meetings, and training;
 - (2) How the UM Program's effectiveness in meeting goals shall be evaluated;
 - (3) How improvements shall be made on a regular basis;
 - (4) How the content of Items I. A. 5. c) – e) in this Scope of Work are addressed and included as a part of the UM Program Plan; and
 - (5) The oversight and control mechanisms to ensure that UM activities meet required standards when they are delegated to an administrative services organization or a DSHS-approved entity.
- i) Contractor shall comply with the DSHS Texas Resilience and Recovery Waiting List Maintenance requirements for all individuals (adult or child/youth) who have requested mental health services from Contractor that Contractor anticipates will not be available upon request for such services:

- (1) Initial Intake and Placement on Waiting Lists – Contractor shall develop and ensure the implementation of procedures to triage and prioritize service needs of individuals determined eligible for a LOC but for which Contractor has reached or exceeded its capacity to provide the LOC. These procedures shall include a process for the assessment of an individual’s urgency of needs using the Child and Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA) and a requirement that they be placed immediately on a waiting list for the unavailable LOCs for which they are determined to be eligible. The waiting list shall include individuals who are underserved due to resource limitations as well as those who have been authorized for LOC – 8 waiting for all services. Individuals with Medicaid entitlement or whose assessment indicates a need for LOC 0-crisis services shall not be placed on a waiting list. All medically necessary services shall be provided in timeframes specified by DSHS. Clients with Medicaid who are determined to be in need of Case Management and/or Medicaid Mental Health Rehabilitative Services shall be authorized for a LOC that meets their needs and shall not be underserved or placed on the waiting list. If an individual is determined to have an urgent need for services (e.g. use of crisis services), they shall be given priority to enter ongoing services.
- (2) Contractor shall ensure there is one Super User for the Adult Needs and Strengths Assessment (ANSA) and one Super User for the Children’s Needs and Strengths Assessment (CANS). One staff person can be the identified Super User for both ANSA and CANS if needed. The individual(s) shall keep the Super User status current in accordance with the Praed Foundations requirements. ANSA and CANS Super Users shall be identified on Form S. If there is a vacancy, Contractor will submit a plan of correction to CMU to ensure that the position is filled and able to perform prescribed activities within 6 months.
- (a) A CANS/ANSA Super User is an individual who is at least QMHP – CS that has met the training requirements indicated in Information Item A.
- (b) Super User will perform a quality assurance training activity at least two times annually with a minimum of 40% of the practitioners who are certified to administer the CANS/ANSA as part of their primary functions. No later than March 15, 2016 and September 15, 2016, Contractor shall report the following:
- (i) Average number of employees certified to administer the CANS/ANSA during the six month reporting period.
- (ii) Total number of unduplicated employees who participated in the quality assurance training activity during the six month reporting period.
- (iii) Sign-in sheet for participation in the quality assurance training activity.
- (iv) Quality assurance training activity agenda
- j) Specific Requirements for Medicaid Recipients –
- (1) General - Contractor shall deliver services to an individual who is a Medicaid recipient and has an identified need for Targeted Case Management or Mental Health Rehabilitative Services, and such an individual shall not be put on the

waiting list. Individuals who were assessed to need Targeted Case Management or Mental Health Rehabilitative Services but did not become Medicaid eligible until after they were placed on the waiting list may not remain on a waiting list for longer than 60 calendar days. The date of eligibility will be the Medicaid Certification date or the Medicaid Effective date, whichever is later. A person who declines all services from Contractor may be taken off the waiting list.

- (2) Mental Health Rehabilitative and Mental Health Targeted Case Management Services (both Intensive and Routine) - Medicaid recipients who are eligible for full Medicaid benefits shall not be placed on a waiting list for medically necessary Targeted Case Management or Mental Health Rehabilitative Services. Contractor shall make these services available to the individual whenever such services are indicated by the uniform assessment and in accordance with the Texas Resilience and Recovery Utilization Management Guidelines. If the Uniform Assessment process recommends that an individual receive a LOC that includes one or both of these services and a Licensed Practitioner of the Healing Arts (LPHA) determines that the service or services are not medically necessary, the LPHA shall document the reasons that the service is not indicated.
- (3) Other Medicaid Mental Health Services - For Medicaid recipients who are eligible for full Medicaid benefits and have an identified need for medically necessary mental health services other than Mental Health Rehabilitative Services and Targeted Case Management (such as counseling or physician's services), Contractor shall remove them from the waiting list and provide these services to the individual or refer the individual to other local Medicaid providers. Contractor shall provide assistance with the referral if requested by the client. Contractor shall document actions taken on behalf of the client.

If Contractor lacks the capacity to deliver the services and no qualified local Medicaid provider is available, Contractor shall identify the nearest qualified Medicaid provider of the needed service or services. If the distance to the nearest available non-local (more than 75 miles from the individual's residence) provider is not, in the individual's opinion, a barrier to the individual accessing services, then Contractor shall refer the individual to the available service provider. Contractor shall document the discussion with the individual and the individual's decision regarding traveling to the non-local provider.

Contractor may place an individual on a waiting list for the needed service only if Contractor lacks the capacity to provide the needed service and there are no other internal or external qualified or accessible providers available to deliver the needed service. In such cases, Contractor shall review the availability of the service monthly in order to ensure that the individual receives the needed service once it becomes available. Contractor shall document the steps taken in the client file.

- (4) Policies and Procedures for Waiting List Management – Contractor shall develop and maintain written policies and procedures that ensure that individuals who are already on a waiting list and subsequently establish Medicaid eligibility are

identified, removed from the waiting list, and provided services as indicated and in accordance with subsections 2.ii and 2.iii above.

k) Contractor shall assess clients on the waiting list at least annually using the Adult or Child and Adolescent Uniform Assessment including the Child and Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA).

l) Monitoring and Maintenance Requirements

(1) Frequency of Monitoring:

(a) Contractor shall ensure that individuals on the waiting list(s) who have an LOC-A 8 (waiting for all services) with an LOC-R of Adult LOCs 3 or 4 and all children/youth on the waiting list are monitored at least once every 30 days from the date of placement on the waiting list to determine the continued need. Contractor shall ensure that individuals on the Waiting List(s) who have an LOC-A 8 (waiting for all services) with an LOC-R of Adult LOCs 1 or 2 are monitored at least once every 90 days from the date of placement on the waiting list to determine the continued need. This monitoring shall be conducted by a QMHP-CS and shall include a brief clinical screening to determine the current urgency of need.

(b) Contractor shall remove individuals placed on the waiting list when the individual begins to receive the recommended LOC, or no longer wants services. Except as described above, Contractor shall allow individuals who seek services to remain on the waiting list if the service need continues to be indicated and the individual desires to remain on the waiting list.

(c) If the client is not able to be contacted during the 30 day period for all children/youth on the waiting list and Adults with LOC-R of 3 or 4, or during the 90 day period for Adults with LOC-R of 1 or 2, Contractor shall document good faith efforts to contact that person or his/her legally authorized representative (LAR) to determine the continued need for services. Good faith efforts are defined as two or more attempts to contact the client, collateral or LAR regarding service needs. (A “collateral” or “collateral contact” is a source of information that is knowledgeable about the consumer or the consumer’s life situation and serves to support or augment the available information relating to a consumer or the consumer’s needs. Possible collateral contacts include, but are not limited to past or present landlords, employers, school officials, neighbors, teachers, day care providers, and friends. One effort to contact must be in the form of a letter.) Other efforts may be phone calls or letters to client’s home, job-site, or school. The QMHP-CS may want to review the CARE system for designated collateral contacts who may assist in locating clients. Contacts with collaterals are subject to DSHS confidentiality requirements. Based on the information gathered, the waiting list data shall be updated. If the client has not been contacted after a good faith effort has been made, the client may be removed from the waiting list. However, the client shall not be removed from the waiting list until at least 30 days after the preceding contact.

(2) Individuals who have limited financial resources

- (a) Contractor shall demonstrate that individuals who are placed on the waiting list for medically necessary services receive a screening for benefits assistance.
- (b) Contractor shall notify its UM staff of dates relevant to each application (filed by or on behalf of a consumer screened or served by Contractor) for medical or other public assistance. For a Medicaid application, such dates include at a minimum, the date which benefits begin (known as the “effective” date) and the date of notification of benefit (known as the “certification” date).
- (3) Waiting List Manual – Contractor shall implement processes defined in the most current version of the Waiting List Maintenance Manual contained in Information Item R.
- (4) An active duty military service member or the spouse or children of an active duty service will be maintained on the waiting list as defined in Information Item R.

6. Oversight of Authority and Provider Functions

Contractor shall:

- a) Objectively monitor and evaluate service delivery and provider performance including providing oversight information to Contractor’s Board.
- b) Ensure that each provider’s non-compliance is corrected.
- c) Require providers to use at least a Level One certified sign language interpreter and to use a Level Three certified sign language interpreter, if available, for persons with hearing impairments who request sign language interpreter services.
- d) Assist in the completion of Mental Health Adult Client or Child and Family surveys as required by DSHS.
- e) Implement a Quality Management Program that includes:
 - (1) A structure that ensures the program is implemented system-wide including the involvement of stakeholders;
 - (2) Allocation of adequate resources for implementation;
 - (3) Oversight by staff members with adequate and appropriate experience in quality management;
 - (4) Activities and processes that address identified clinical and organizational problems including data integrity and the processes to evaluate and continuously improve data accuracy;
 - (5) An established set of remedies and timeline options for areas that need improvement or correction;
 - (6) Routine reporting of Quality Management Program activities to its governing body, providers, other appropriate organizational staff members, and community stakeholders;
 - (7) Consistent analysis of grievance, appeal, fair hearings, and expedited hearings, mortality, and incident/accident data as part of the Quality Management process;
 - (8) Measuring, assessing, and improving Contractor’s local authority functions;

- (9) Processes to systematically monitor, analyze, and improve performance of quality management activities, administrative services, client services and outcomes for individuals;
- (10) A biennial update of the Quality Management Plan approved by the governing board;
- (11) Review of provider treatment to determine whether it is consistent with DSHS' approved evidence-based practices, accuracy of assessments, and treatment planning;
- (12) Ongoing monitoring of the quality of access to services, service delivery, and continuity of services;
- (13) Provision of technical assistance to providers related to quality oversight necessary to improve the quality and accountability of provider services;
- (14) Use of reports and data from DSHS to inform performance improvement activities and assessment of unmet needs of individuals, service delivery problems, and effectiveness of authority functions for the LSA;
- (15) Oversight of all services, contracts, and subcontractors, regardless of the amount of funding;
- (16) Oversight to ensure compliance with and the quality of the TRR practices to include monitoring fidelity to the service models defined by DSHS and requiring providers to participate in oversight; including an annual continuous quality improvement measurement of the fidelity of evidence-based practices (EBP) for children and adolescent services utilizing the EBP fidelity tools approved by DSHS.
 - (a) Fidelity monitoring is required for the following CMH EBPs:
 - i. TF-CBT
 - ii. Seeking Safety
 - iii. Aggression Replacement Techniques
 - (b) Fidelity monitoring is recommended for the following CMH EBPs and promising practices:
 - i. Wraparound Planning
 - ii. Nurturing Parenting
 - iii. Safety Planning Intervention: The Safety Plan Intervention (SPI; Stanley & Brown, 2011) is a brief 20 to 45 minute intervention that provides an individual with a set of steps that can be used progressively to attempt to reduce risk and maintain safety when suicidal thoughts emerge. SPI should follow a comprehensive risk assessment after strong rapport has been developed. Safety plans should be developed within a collaborative process among the provider, the individual at risk, and his or her close family or friends. Safety planning can be a stand-alone intervention, utilized during crisis contacts (e.g., in emergency departments, mobile crisis contacts) or as a part of an on-going treatment relationship.
- (17) Mechanisms to measure, assess, and reduce incidents of client abuse, neglect and exploitation and improving the client rights protection processes;
- (18) Risk Management processes such as competency determinations and the management and reporting of incidents and deaths;

- (19) Coordination of activities and information with the UM Program including participation in UM oversight activities as defined and scheduled by DSHS, including but not limited to submitting data and supporting documentation, performance and submitting results of self-audits, and participating in DSHS onsite reviews; and
 - (20) Oversight of new initiatives such as Crisis Redesign, Children’s Mental Health Service Delivery Re-Design, Local Provider Network Development, Jail Diversion, and Outpatient Competency Restoration.
- f) Ensure all providers are implementing TRR, as specified by DSHS and providing evidence-based practices in accordance with the Fidelity Manual. Providers who do not meet adequate implementation shall submit a Plan of Improvement (POI) for identified problems and meet the following standards:
- (1) Within five business days after receipt of a request from DSHS, develop a POI that adequately addresses the correction of any critical health, safety, rights, abuse and neglect issues identified by DSHS, and that includes a description of local oversight activities to monitor and maintain the correction of the identified problem, and submit to DSHS for approval; and
 - (2) Within 14 business days after receipt of a request from DSHS, develop a POI that adequately addresses the correction of organizational, clinical or compliance problems identified by DSHS during oversight activities and that includes a description of local oversight activities to monitor and maintain the improvement of the identified problem, and submit to DSHS for approval in accordance with the Submission Calendar.
- g) If applicable, submit to DSHS evidence of initial or continued accreditation by a national accreditation organization (e.g., American Association of Suicidology, Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), and The Council on Quality and Leadership (CQL), in accordance with the Submission Calendar. The submission shall include the accreditation review report and any plan of improvement created by Contractor in response to the accreditation review report.
- h) Ensure that Contractor’s buildings and associated properties are compliant with the Texas Accessibility Standards (TAS), Texas Health and Safety Code, Texas Department of Licensing and Regulation requirements, National Fire Protection Association (NFPA) Life Safety Code or the International Fire Code.
- i) Ensure that Contractor’s Americans with Disabilities Act (ADA) Self-Evaluation and Transition Plan (ADA Plan) is reviewed by Contractor at least annually and updated as necessary, and ensure that the following information is posted prominently at each service location:
- (1) The name, address, telephone number, TDD telephone number, fax number and e-mail address of the ADA and the Rehabilitation Act of 1973 Coordinator(s);
 - (2) The location at which the ADA Plan may be viewed; and
 - (3) The process for requesting and obtaining copies of the ADA Plan.

j) Contractor shall incorporate jail diversion strategies into the authority's resilience and recovery practices to reduce involvement with the criminal justice system.

(1) Jail diversion strategies shall address the needs of individuals with the following disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5):

- (a) schizophrenia
- (b) bipolar disorder
- (c) post-traumatic stress disorder
- (d) schizoaffective disorder, including bipolar and depressive types
- (e) anxiety disorder; and
- (f) delusional disorder.

(2) Plans for jail diversion shall be incorporated into the Consolidated Local Service Plan.

7. Disaster Services.

In the event of a local, state or federal emergency, including natural, man-made, criminal, terrorist, bioterrorism or other public health emergency or event as declared by the Texas Division of Emergency Management, Contractor shall assist DSHS and/or the DSHS Disaster Behavioral Health Services (DBHS) program in providing disaster services to mitigate the psychological trauma experienced by victims, survivors, and responders to such an emergency or event. The disaster services may need to be provided outside Contractor's LSA. Contractor shall assist individuals and their families in returning to a normal (pre-disaster) level of functioning and shall assist in reducing the psychological and physical effects of acute and/or prolonged distress. In the event clients already receiving mental health services are affected, Contractor shall provide disaster services to the affected individuals in conjunction with the individual's current support system. Contractor shall provide disaster services in a manner that is most responsive to the needs of the emergency, cost effective, and as unobtrusive as possible to the primary services provided by Contractor under this Contract. Contractor shall be prepared to provide disaster services with little or no advance notice.

Contractor shall provide disaster services that include but are not limited to: Psychological First Aid (PFA), International Critical Incident Stress Foundation (ICISF), Critical Incident Stress Management (CISM), crisis counseling, stress management, and the provision of referral services. Contractor shall use standardized data gathering, expense tracking and reporting forms as detailed in the Disaster Behavioral Health (DBH) Toolkit. For additional information on PFA, DBH Toolkit, and ICISF CISM, see: <http://www.dshs.state.tx.us/mhsa-disaster> and <http://www.dshs.state.tx.us/mhsa-disaster/cism>.

Contractor's responsibilities may include, but shall not be limited to, the following:

- a) every six months beginning with the first quarter, provide the DBHS office the names and 24-hour contact information of two mental health professionals who are trained in providing mental health and/or substance abuse services, as well as the names and 24-

- hour contact information of Contractor's Risk Manager or Safety Officer (include information on whether these identified individuals have been trained in PFA, DBH Toolkit, Incident Command System 100, 200, 300, 700 and/or ICISF CISM) on Form T;
- b) collaborate with DSHS to coordinate disaster/incident response, including but not limited to status reports, the provision of screening, assessment, outreach, referral, crisis counseling, stress management, data gathering and/or other appropriate services as necessary;
 - c) assign employees to assist DSHS to meet staffing needs for morgues, schools, hospitals, Disaster Recovery Centers (DRCs), Medical Operation Center (MOC), points of distribution (POD), community support centers, death notification centers, family assistance centers (FAC), mass inoculation sites during local, state or federal emergencies;
 - d) contract with DSHS to provide crisis counseling services following designated federal emergency declarations. These services are funded through the Federal Emergency Management Agency (FEMA)-Crisis Counseling Training and Assistance Program (CCP). CCP services include housing, hiring, and co-managing CCP Team(s); see the following link for further federal guidance (<http://media.samhsa.gov/DTAC-CCPToolkit/intro.htm>); and
 - e) participate in programs, exercises, drills, and training relating to the provision of public health services in disasters that focus on mental health and substance abuse education and preparedness.
8. Youth Empowerment Services (YES) Waiver The Texas Health and Human Services Commission (HHSC) is the Texas Medicaid Agency and has delegated operation of the 1915(c) Medicaid Home and Community-Based Services Waiver Program called YES Waiver to the Department of State Health Services (DSHS) as authorized by Texas Government Code §531.0055. The YES Waiver is administered under Social Security Act §1915(c). The purpose of this Scope of Work is to set out the requirements of the Contractor in administering the YES Waiver (Waiver) in the County(ies) identified in Section III of the Performance Contract Notebook (PCN). The YES Waiver serves to prevent or reduce institutionalization of children and adolescents ages 3 – 18 with serious emotional disturbance (SED), enable more flexibility in providing intensive community-based services for children and adolescents with SED, and provide support for their families by improving access to services.

The Centers for Medicare and Medicaid Services (CMS) have approval of the counties where YES Waiver is available. HHSC and DSHS determine financial eligibility for services under the Waiver from standards outlined in the Texas Administrative Code used to determine eligibility for Medicaid in institutions. Under these standards, parental income is not counted, which reduces the current incentive for parents to relinquish custody to obtain access to Medicaid coverage for mental health treatment.

Contractor shall comply with all policies outlined in the current version of the YES Waiver Policy and Procedure Manual posted at: <http://www.dshs.state.tx.us/mhsa/yes/>. To the extent this Contract Attachment imposes a higher standard, or additional requirements beyond those

required by the Manual, the terms of this Contract Attachment will control. This includes but is not limited to:

- a) Manage and maintain an Inquiry List of individuals who are seeking Waiver services. This includes but is not limited to:
 - (1) Establishing and maintaining an Inquiry list phone line with voice messaging capabilities;
 - (2) Answering or returning calls made to the Inquiry list phone line within 1 business day;
 - (3) Registering clients on the list in the order in which their call was received
 - (4) Assessing for demographic eligibility via phone in the initial return phone call; and
 - (5) Complete a face-to-face clinical eligibility assessment within 7 business days of the initial demographic eligibility determination contact. Exceptions, to the timeline are considered only at the request of the client and/or legally authorized representative (LAR), and must be documented within client records.
- b) Facilitate waiver enrollment of interested individuals by completing all activities necessary for waiver enrollment. This includes but is not limited to:
 - (1) For individuals found to be clinically eligible, complete an Initial Service Authorization Request and Individual Plan of Care (IPC) to occur within 10 business days of DSHS authorizing Clinical Eligibility Determination. Exceptions, only at the request of the client and/or legally authorized representative (LAR), must be documented within client records.
 - (2) Enrollment activities outlined in the YES Waiver Policy and Procedure Manual posted at: <http://www.dshs.state.tx.us/mhsa/yes/>.
- c) Assist clients in obtaining and maintaining Medicaid eligibility;
- d) Facilitate the development of participant IPCs in accordance with the YES Waiver Policy and Procedure Manual posted at: <http://www.dshs.state.tx.us/mhsa/yes/>.
- e) Submit to Clinical Management for Behavioral Health Services (CMBHS) completed Individual Plans of Care for approval within 5 business days of completion and in accordance with DSHS policy;
- f) Provide Intensive Case Management using the Wraparound Planning Process as required and outlined in 25 TAC Chapter 412, Subchapter I;
- g) Provide transition planning and service coordination beginning at least six months prior to the Waiver participant's 19th birthday;
- h) Monitor service utilization for compliance with the DSHS approved IPC for each Waiver participant;
- i) Provide engagement activities to facilitate participant participation in all indicated and approved Waiver services outlined in the IPC;
- j) Perform Quality Management (QM) activities. Contractor shall collect data, measure, assess, and work to improve dimensions of performance through focus on the following aspects of care:
 - (1) Timely access to services;
 - (2) Timely enrollment of Waiver participants (LMHA only);
 - (3) Plans of cares and services are based on underlying needs and outcome statements;
 - (4) Services provided according to the Waiver participant's approved Individual Plan of Care;

- (5) Provider participation in child and family team meetings;
- (6) Assuring development and revision of Individual Plans of Care;
- (7) Health and safety risk factors are identified and updated;
- (8) Collection and analysis of critical incident data;
- (9) Providers are credentialed and trained;
- (10) Adherence to established policies and procedures; and
- (11) Continuity of care.

Contractor shall include these activities in the QM plan outlined in Section II.E.

- k) Maintain open communication and coordination with each Waiver Provider;
- l) Cooperate with and assist HHSC, DSHS and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse, including the Office of Inspector General at HHSC;
- m) Allow DSHS and/or HHSC access to information or records related to Waiver participants, fully permitted by applicable law, rule or regulation. This information shall be provided at no cost to the requesting agency; and
- n) Allow representatives of DSHS, HHSC, and The Texas Department of Family and Protective Services, Office of the Attorney General Medicaid Fraud, and United States Department of Health and Human Services full and free access to Contractor's staff or subcontractors and all locations where the Contractor or subcontractors perform activities related to the Waiver.

B. Adult Services

1. Community Services

- a) Contractor shall provide the community-based services outlined in Health and Safety Code Chapter 534, §534.053, which are incorporated into services defined in Information Item G.
- b) Contractor shall establish a reasonable standard charge for each service containing an asterisk (i.e., *) in Information Item G.

2. Populations Served

- a) Adult Mental Health (MH) Priority Population - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, anxiety disorder, attention deficit/hyperactivity disorder, delusional disorder, bulimia nervosa, anorexia nervosa or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.
- b) Initial Eligibility through September 30, 2015:
 - (1) An individual age 18 or older who has a diagnosis of:
 - (a) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition - Text Revision (DSM-IV TR) diagnostic codes: 295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90.

- (b) bi-polar disorder as defined in the following DSM-IV TR diagnostic codes:
296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41,
296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53,
296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65,
296.66, 296.7, 296.80, 296.89.
 - (c) major depression as defined in the following DSM-IV TR diagnostic codes:
296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31,
296.32, 296.33, 296.34, 296.35, and 296.36; with a Global Assessment of
Functioning (GAF) of 50 or below at intake.
 - (2) An individual age 18 or older who has a diagnosis other than those listed in
I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or
less and needs on-going MH services; or
 - (3) An individual age 18 or older who was served in children's MH services and
meets the children's MH priority population definition prior to turning 18 is
considered eligible for one year.
- c) Individuals with only the following diagnoses are excluded from this provision:
- (1) Substance Abuse as defined in the following DSM-IV TR diagnostic codes:
291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.89, 291.9, 292.0, 292.11, 292.12,
292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 303.00, 303.90, 304.00, 304.10,
304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 305.00, 305.1, 305.20, 305.30,
305.40, 305.50, 305.60, 305.70, 305.90.
 - (2) IDD as defined in the following DSM-IV TR diagnostic codes: 317, 318.0, 318.1,
318.2, 319.
 - (3) Pervasive Developmental Disorder as defined in the following DSM-IV TR
diagnostic codes: 299.00, 299.10, 299.80.
- d) Initial Eligibility on and after October 1, 2015:
- (1) An individual age 18 or older who has a diagnosis of:
 - (a) schizophrenia as defined in the following Diagnostic and Statistical Manual,
Fifth Edition (DSM-5) diagnostic codes: F20.81, F25.0, F20.9, F25.1
 - (b) bi-polar disorder as defined in the following DSM-5 diagnostic codes:
F31.0, F31.9, F31.11, F31.12, F31.13, F31.2, F31.73, F31.71,
F31.74, F31.72, F31.31, F31.32, F31.4, F31.5, F31.75, F31.76, F31.89,
F31.81
 - (c) major depression as defined in the following DSM-5 diagnostic codes:
F32.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F33.9, F33.0, F33.1, F33.2,
F33.3, F33.41, and F33.42; with a Global Assessment of Functioning (GAF)
of 50 or below at intake.
 - (2) An individual age 18 or older who has a mental health diagnosis other than those
listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is
50 or less and needs on-going MH services; or

- (3) An individual age 18 or older who was served in children’s MH services and meets the children’s MH priority population definition prior to turning 18 is considered eligible for one year.
- e) Individuals with only the following diagnoses are excluded from this provision:
- (1) Substance Related Disorders as defined in the following DSM-5 diagnostic codes:
F10.10, F10.121, F10.129, F10.14, F10.159, F10.180, F10.181, F10.20, F10.221, F10.229, F10.231, F10.232, F10.239, F10.24, F10.259, F10.26, F10.27, F10.280, F10.281, F10.182 F10.288, F10.921, F10.929, F10.94, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, F11.10, F11.121, F11.122, F11.129, F11.14, F11.181, F11.188, F11.20, F11.221, F11.222, F11.229, F11.23, F11.24, F11.182, F11.281, F11.282, F11.288, F11.921, F11.922, F11.929, F11.94, F11.981, F11.982, F11.988, F11.99, F12.10, F12.121, F12.122, F12.129, F12.159, F12.180, F12.188, F12.20, F12.221, F12.222, F12.229, F12.259, F12.280, F12.288, F12.921, F12.922, F12.929, F12.959, F12.980, F12.988, F12.99, F13.10, F13.121, F13.129, F13.14, F13.159, F13.180, F13.181, F13.182, F13.20, F13.221, F13.229, F13.231, F13.232, F13.239, F13.24, F13.259, F13.27, F13.280, F13.281, F13.282, F13.288, F13.921, F13.929, F13.94, F13.959, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.10, F14.121, F14.122, F14.129, F14.14, F14.159, F14.180, F14.181, F14.182, F14.188, F14.20, F14.221, F14.222, F14.229, F14.23, F14.24, F14.259, F14.280, F14.281, F14.282, F14.288, F14.921, F14.922, F14.929, F14.94, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15. 229, F15.10, F15.121, F15.122, F15.129, F15.14, F15.159, F15.180, , F15.181, F15.188, F15.20, F15.221, F15.222, F15.23, F15.24, F15.259, F15.280, F15.281, F15.288, F15.921, F15.922, , F15.929, F15.93, F15.94, F15.959, F15.980, F15.981, F15.988, F15.99, F16.10, F16.121, F16.129, F16.14, F16.159, F16.180, F16.20, , F16.221, F16.229, F16.24, F16.259, F16.280, F16.921, F16.929, F16.94, F16.959, F16.980, F16.983, F16.99, F17.200, F17.203, F17.208, F17.209, F18.10, F18.121, F18.129, F18.14, F18.159, F18.17, F18.180, F18.188, F18.20, F18.221, F18.229, F18.24, F18.259, F18.27, F18.280, F18.288, F18.921, F18.929, F18.94, F18.959, F18.97, F18.980, F18.988, F18.99, F19.10, F19.121, F19.129, F19.14, F19.159, F19.17, F19.180, F19.181, F19.182, F19.188, F19.20, F19.221, F19.229, F19.231, F19.239, F19.24, F19.259, F19.27, F19.280, F19.281, F19.282, F19.288, F19.921, F19.94, F19.959, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, Z72.0.
 - (2) IDD as defined in the following DSM-5 diagnostic codes: F70, F71, F72, F73, F79.
 - (3) Autism spectrum disorder as defined in the following DSM-5 diagnostic code: F84.0.
- f) Service Determination:
- (1) In determining services to be provided to the priority and target populations, the choice of and admission to medically necessary services is determined jointly by the individual seeking service and Contractor.
 - (2) Criteria used to make these determinations are the recommended LOC (LOC-R) of the individual as derived from the UA, the needs of the individual, Texas Resilience and Recovery Utilization Management Guidelines, and the availability of resources. Clients authorized for care by Contractor through a clinical override are eligible for the duration of the authorization.

g) Continued Eligibility for Services:

- (1) Reassessment by the provider and reauthorization of services by Contractor determines continued need for services. This activity is completed according to the UA protocols and Texas Resilience and Recovery Utilization Management Guidelines.
- (2) Assignment of diagnosis in CARE is required at any time the Axis I diagnosis changes and at least annually from the last diagnosis entered into CARE.
- (3) The LPHA's determination of diagnosis shall include a face-to-face or via tele-medicine/tele-health interview with the individual.
- (4) Eligibility for clients whose diagnosis is Major Depression includes a GAF of 50 or below at intake only. Changes in GAF scores after the initial eligibility determination do not make clients ineligible.

h) Documentation Required:

In order to assign a diagnosis across all 5 axes to an individual, documentation of the required diagnostic criteria, as well as the specific justification of GAF score, shall be included in the client record. This information shall be included as a part of the required assessment information.

i) UA Requirements:

- (1) The DSHS-approved UA for Adults includes the following instruments:
 - (a) Adult Needs and Strengths Assessment (ANSA).
 - (b) Diagnosis-Specific Clinical Rating Scales;
 - (c) Community Data; and.
 - (d) Authorized LOC.
- (2) The above instruments are required to be completed once an individual has been screened and determined in need of assessment by Contractor. The initial assessment is the clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental or other information from the individual seeking services in order to determine specific treatment and support needs.
- (3) Staff administering the instruments must have documented training in the use of the instruments and must be a QMHP-CS, with the exception of the Diagnosis-Specific Clinical Rating Scales which may be administered by a QMHP-CS or Licensed Vocational Nurse (LVN). Staff administering the instruments must have documentation of certification in the ANSA or CANS;
- (4) The UA shall be administered according to the timeframes delineated in Information Item C at <http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>.

j) Adult Data Submission Requirements:

Contractor shall submit all required information in compliance with the schedule established by DSHS through either CARE/WebCare or Clinical Management for Behavioral Health Services System (CMBHS) as set forth in the following table:

| Required Submission | Approved Data Submission Methods | | | |
|--|--|-------------|---------------------|--------------------|
| | CMBHS Online(Use of the CMBHS web interface) | CMBHS Batch | CARE/WebCare Online | CARE/WebCare Batch |
| TTR Adult Uniform Assessment using the Adult Needs and Strengths Assessment (ANSA) | Yes | Yes | No | No |
| Assignments (Service, Activity & Destination) | No | No | Yes | Yes |
| Case Maintenance (Case delete, ID merge, ID split) | No | No | Yes | No |
| Client Profile (new and update) | Yes | No | Yes | Yes |
| Diagnosis | Yes | No | Yes | Yes |
| Follow up Contact | No | No | Yes | Yes |
| CARE County of Residence | No | No | Yes | No |
| Separations | No | No | Yes | No |
| Consent | Yes | No | N/A | N/A |

Contractor may only batch to CMBHS if Contractor has submitted Form U CMBHS Assessment Attestation regarding data exchange

3. Contractor shall no longer enter, and DSHS will no longer accept, MH Uniform Assessment information through WebCare or the CARE System. MH Uniform Assessment data must be entered into CMBHS online or through a DSHS approved data exchange process.
4. Service Requirements
Contractor shall:
 - a) Comply with UA requirements for adults in accordance with Section I.B.8. The UA is not required for individuals whose services are not funded with funds paid to Contractor under this Scope of Work;
 - b) Implement a Patient and Family Education Program (PFEP) in accordance with psychosocial treatment recommendations and information for patient/family education available at: <http://www.dshs.state.tx.us/mh/patient-family-ed/>. Recommendations and information related to medications used to treat mental illness may be found at the following website: <http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml>. If clients and/or their families and caregivers have not been educated about their diagnosis, the reason for the lack of education shall be documented in the clinical progress note.
 - c) Implement TRR and apply to all clients whose services are funded with Scope of Work funds:

- (1) Develop a service delivery system in accordance with the most current version of DSHS's Texas Resilience and Recovery Utilization Management Guidelines, Adult Needs and Strengths Assessment (ANSA) and Fidelity Instruments;
- (2) Ensure that each adult who is identified as being potentially in need of services is screened to determine if services may be warranted;
- (3) Ensure that clients seeking services are assessed to determine if they meet the requirements of priority population and if so, ensure that a full assessment is conducted and documented using the most current version of the DSHS UA instruments. Individuals who are admitted into services whose services are not funded in whole or in part with contract funds are exempt from inclusion in TRR regardless of priority population status;
- (4) Make available to each client recommended and authorized for a LOC, as indicated by the Adult Needs and Strengths Assessment (ANSA) all services and supports within the authorized LOC (LOC-A):
 - (a) If a non-Medicaid-eligible individual cannot be served in the recommended LOC, or if the individual refuses the recommended LOC, individual may be served at the next most appropriate LOC. If no services are available at the next most appropriate LOC, the non-Medicaid-eligible individual shall be placed and monitored on a waiting list;
 - (b) Medicaid-eligible individuals may not have services denied, reduced, suspended, or terminated due to lack of available resources; and
 - (c) If a Medicaid eligible individual refuses the recommended LOC, the individual may be served at the next most appropriate LOC as long as the services within that LOC are appropriate and medically necessary to address the individual's mental illness.
- (5) Ensure Medicaid eligible individuals are provided with any medically necessary Medicaid funded MH services within the recommended LOC without undue delay;
- (6) Ensure that Cognitive-Behavioral Therapy (CBT) is provided by an LPHA, practicing within the scope of a license, or when appropriate and not in conflict with billing requirements, by an individual with a master's degree in a human services field (e.g., psychology, social work, family therapy or counseling) who is pursuing licensure under the direct supervision of an LPHA. The LPHA providing CBT shall meet DSHS competency requirements as outlined in the Information Item A (CBT Competency Policy);
- (7) Ensure that providers of services and supports within TRR are trained in the DSHS-approved evidence-based practices prior to the provision of these services and supports. DSHS-approved evidence-based practices are:
 - (a) Assertive Community Treatment (services): Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (services);
 - (b) Counseling: Cognitive Behavioral Therapy;
 - (c) Psychosocial Rehabilitation: SAMHSA Illness Management and Recovery;
 - (d) Supported Employment: Dartmouth Psychiatric Research Center – Individual; Placement and Support or SAMHSA Supported Employment;
 - (e) Supported Housing: SAMHSA Permanent Supported Housing; and

- (f) Co-Occurring Psychiatric and Substance Use Disorders (COPSD).
- (8) Ensure that supervisors of services and supports within TRR are trained as trainers in the DSHS-approved evidence-based practices, are trained in the evidence-based practices, or have provided the evidence-based practices prior to the supervision of the evidence-based practices. Supervisors must complete this requirement within 180 days of assuming a supervisory position. If supervisors are unable to complete this requirement within 180 days of assuming the supervisory position, the LMHA must submit a plan to the department outlining how the supervisor will fulfill this requirement;
 - (9) Use the uniform assessment and other relevant clinical information to document the assessment of individuals seeking services and to reassess current clients in services when update assessments are due or significant changes in functioning occur, to determine the recommended LOC for a client;
 - (10) Utilize information from the Adult Needs and Strengths Assessment (ANSA) and other relevant clinical information to:
 - (a) Recommend a LOC;
 - (b) Determine whether the client should be transferred to another provider; and
 - (c) Determine if a client should be discharged from services.
 - (11) Use the flexible funds that shall be made available by Contractor, in accordance with the Texas Resilience and Recovery Utilization Management Guidelines;
 - (12) Assertive Community Treatment (ACT) includes Urban ACT and Rural ACT programs serving clients with an LOC-R = 4. The baseline of numbers of individuals who need ACT services for Urban ACT and Rural ACT shall be determined by data reports based on the combined average number of clients with an LOC-R = 4 over the last two quarters of FY2010 and the first two quarters of FY2011. The Urban ACT team serves a client base of 60 or more within a local service area or has a population density of 300 or more persons per square mile in the local service area. The Rural ACT team serves a client base of less than 60 within a local service area. ACT services provided by Contractor shall meet the minimum Texas Resilience and Recovery Utilization Management Guidelines for LOC 4, and shall follow the most current Dartmouth Assertive Community Treatment Scale (DACTS) Fidelity Instrument, as well as, the rules and guidelines for Urban ACT or Rural ACT;
 - (13) Application of Evidence-Based Practices: If an individual has a documented need (scoring a 2 or 3) on the Employment or the Residential Stability items of the ANSA, contractor shall document encounters using the H2017U3 for Employment needs and H2017U2 for Residential Stability. These encounters will follow documentation rules outlined in 25 TAC, Chapter 416, Subchapter A.
 - (14) Contractor shall serve individuals with monies allocated through Crisis Redesign, for engagement, transition, and intensive ongoing services in accordance with Texas Resilience and Recovery Utilization Management Guidelines. CARE Report III shall be completed in accordance with Information Item D and submission timelines as outlined in Information Item S. Performance measures are outlined in Section II. G.; and
 - (15) Contractor shall maintain access to CMBHS even if Contractor utilizes an approved batch process.

- d) Submit encounter data for all services according to the procedures, instructions and schedule established by DSHS, including all required data fields and values in the current version of the DSHS Community Mental Health Service Array. The current version of DSHS Community Mental Health Service Array (i.e., Report Name: INFO Mental Health Service Array Combined) can be found in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW), in the General Warehouse Information, Specifications subfolder.

- e) Comply with the following Medicaid-related items:
 - (1) Contract with DSHS to be a provider of Medicaid MH Rehabilitative Services;
 - (2) Contract with DSHS to be a provider of Medicaid MH Case Management and with Health and Human Services Commission (HHSC) to participate in Medicaid Administrative Claiming;
 - (3) Recognize that funding earned through billings to Texas Medicaid and Healthcare Partnership (TMHP) for Medicaid MH Case Management and Medicaid MH Rehabilitative Services represents the federal share and the State match; and
 - (4) Submit billing for the provision of Medicaid MH Case Management and Medicaid MH Rehabilitative Services to TMHP.

- f) Utilize non-contract funds and other funding sources (e.g., any person or entity who has the legal responsibility for paying all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other Federal, State, local, and private funding sources) whenever possible to maximize Contractor's financial resources. This includes:
 - (1) Enroll in the CHIP and bill CHIP for services covered under that plan;
 - (2) Become a Medicaid provider and bill Medicaid for services covered under that plan;
 - (3) Provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs;
 - (4) Comply with the Charges for Community Services Rule as set forth in Title 25, Part 1, Chapter 412, Subchapter C of the Texas Administrative Code to maximize reimbursement from individuals with an ability to pay for services provided;
 - (5) Bill all other funding sources for services provided under this Contract before submitting any request for reimbursement to DSHS; and
 - (6) Provide all billing functions at no cost to the client.
 - (7) Expend TANF transfer to Title XX and Base Title XX funds to provide comprehensive community MH services to clients with severe and persistent mental illness. Contractor shall utilize the funds under 42 USC §1397 (also known as Title XX of the Social Security Act) for the provision of the following services to clients in the priority population and report this information on Form L:
 - (a) Case management services, which are services or activities for the arrangement, coordination, and monitoring of services to meet the needs of individuals and families. Component services and activities may include individual service plan development, counseling, monitoring, developing,

securing, and coordinating services; monitoring and evaluating client progress; and assuring that clients' rights are protected; this service includes Routine Case Management as defined in Information Item G of the Performance Contract.

- (b) Education and Training Services, which are those services provided to improve knowledge or daily living skills and to enhance cultural opportunities. Services may include instruction or training in, but are not limited to, such issues as consumer education, health education, community protection and safety education, literacy education, English as a second language, and General Educational Development (G.E.D.) Component services or activities may include screening, assessment and testing; individual or group instruction; tutoring; provision of books, supplies and instructional material; counseling; transportation; and referral to community resources.

This service includes Psychosocial Rehabilitative Services and Skills Training and Development Services as defined in Information Item G of the Performance Contract.

- (c) Housing Services

Housing services are those services or activities designed to assist individuals or families in locating, obtaining, or retaining suitable housing. Component services or activities may include tenant counseling; helping individuals and families to identify and correct substandard housing conditions on behalf of individuals and families who are unable to protect their own interests; and assisting individuals and families to understand leases, secure utilities, make moving arrangements and minor renovations.

This service includes Supported Housing as defined in Information Item G of the Performance Contract.

- (d) Employment Services, which are those services or activities provided to assist individuals in securing employment or acquiring or learning skills that promote opportunities for employment. Component services or activities may include employment screening, assessment, or testing; structured job skills and job -seeking skills; specialized therapy (occupational, speech, physical); special training and tutoring, including literacy training and pre-vocational training; provision of books, supplies and instructional material; counseling, transportation; and referral to community resources;

This service includes Supported Employment as defined in Information Item G of the Performance Contract.

- (e) Counseling services, which are services or activities that apply therapeutic processes to personal, family, situational, or occupational problems in order to bring about a positive resolution of the problem or improved individual or family functioning or circumstances. Problem areas may include:

- i. Family and marital relationships;
- ii. Parent-child problems; or
- iii. Drug abuse when in conjunction with a serious emotional disturbance;

This service includes Counseling as defined in Information Item G of the Performance Contract.

(f) Health Related and Home Health Services

Health related and home health services are those in-home or out-of-home services or activities designed to assist individuals and families to attain and maintain a favorable condition of health. Component services and activities may include providing an analysis or assessment of an individual's health problems and the development of a treatment plan; assisting individuals to identify and understand their health needs; assisting individuals to locate, provide or secure, and utilize appropriate medical treatment, preventive medical care, and health maintenance services, including in-home health services and emergency medical services; and providing follow-up services as needed;

This service includes Pharmacological Management as defined in Information Item G of the Performance Contract.

(g) Other services meeting the requirement of TANF transfer to Title XX or BASE Title XX as approved by the Department.

- g) Provide services to all clients without regard to the client's history of arrest, charge, fine, indictment, incarceration, sentence, conviction, probation, deferred adjudication, or community supervision for a criminal offense.
- h) Develop and implement written procedures to identify clients with COPSD, identify available resources, provide referrals and continuity of care for ongoing services as necessary to address the client's unmet substance use treatment needs in accordance with 25 TAC, Chapter 411, Subchapter N. Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications.
- i) Conduct all initial and on-going diagnostic assessments face-to-face or by tele-medicine/tele-health with the individual to determine priority population eligibility.
- j) Submit financial data regarding co-pays, deductibles, and premiums related to Medicare Part D or other information related to expenditures for medications as requested by DSHS and in the form and format prescribed by DSHS.
- k) Implement crisis services in compliance with the standards outlined in Information Item V.

C. Children's Services

1. Community Services

- a) Contractor shall provide the community-based services outlined in Health and Safety Code Chapter 534, § 534.053, which are incorporated into services defined in Information Item G.
- b) Contractor shall establish a reasonable standard charge for each service containing an asterisk (i.e., *) in Information Item G.

2. Populations Served

- a) Child and Youth Mental Health (MH) Priority Population – children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:
- (1) Have a serious functional impairment; or
 - (2) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
 - (3) Are enrolled in a school system’s special education program because of serious emotional disturbance.

b) CMH Ineligible Codes:

- (1) Ineligible single diagnoses of substance abuse: (same as AMH)
Substance Related Disorders as defined in the following DSM-5 diagnostic codes: F10.10, F10.121, F10.129, F10.14, F10.159, F10.180, F10.181, F10.20, F10.221, F10.229, F10.231, F10.232, F10.239, F10.24, F10.259, F10.26, F10.27, F10.280, F10.281, F10.182 F10.288, F10.921, F10.929, F10.94, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, F11.10, F11.121, F11.122, F11.129, F11.14, F11.181, F11.188, F11.20, F11.221, F11.222, F11.229, F11.23, F11.24, F11.182, F11.281, F11.282, F11.288, F11.921, F11.922, F11.929, F11.94, F11.981, F11.982, F11.988, F11.99, F12.10, F12.121, F12.122, F12.129, F12.159, F12.180, F12.188, F12.20, F12.221, F12.222, F12.229, F12.259, F12.280, F12.288, F12.921, F12.922, F12.929, F12.959, F12.980, F12.988, F12.99, F13.10, F13.121, F13.129, F13.14, F13.159, F13.180, F13.181, F13.182, F13.20, F13.221, F13.229, F13.231, F13.232, F13.239, F13.24, F13.259, F13.27, F13.280, F13.281, F13.282, F13.288, F13.921, F13.929, F13.94, F13.959, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.10, F14.121, F14.122, F14.129, F14.14, F14.159, F14.180, F14.181, F14.182, F14.188, F14.20, F14.221, F14.222, F14.229, F14.23, F14.24, F14.259, F14.280, F14.281, F14.282, F14.288, F14.921, F14.922, F14.929, F14.94, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.229, F15.10, F15.121, F15.122, F15.129, F15.14, F15.159, , F15.180, F15.181, F15.188, F15.20, F15.221, F15.222, F15.23, F15.24, F15.259, F15.280, F15.281, F15.288, F15.921, F15.922, , F15.929, F15.93, F15.94, F15.959, F15.980, F15.981, F15.988, F15.99, F16.10, F16.121, F16.129, F16.14, F16.159, F16.180, F16.20, F16.221, , F16.229, F16.24, F16.259, F16.280, F16.921, F16.929, F16.94, F16.959, F16.980, F16.983, F16.99, F17.200, F17.203, F17.208, F17.209, F18.10, F18.121, F18.129, F18.14, F18.159, F18.17, F18.180, F18.188, F18.20, F18.221, F18.229, F18.24, F18.259, F18.27, F18.280, F18.288, F18.921, F18.929, F18.94, F18.959, F18.97, F18.980, F18.988, F18.99, F19.10, F19.121, F19.129, F19.14, F19.159, F19.17, F19.180, F19.181, F19.182, F19.188, F19.20, F19.221, F19.229, F19.231, F19.239, F19.24, F19.259, F19.27, F19.280, F19.281, F19.282, F19.288, F19.921, F19.94, F19.959, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, Z72.0.
- (2) Ineligible diagnoses for IDD (same as AMH): F70, F71, F72, F73, F79.
- (3) Ineligible diagnosis for Autism spectrum disorder: F84.0

c) Age Limitations:

- (1) Children under the age of three who have a diagnosed physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and

- (2) Youth 17 years old and younger must be screened for Children’s Mental Health (CMH) services. Youth receiving CMH services who are approaching their 18th birthday and continue to need mental health services shall either be transferred to Adult Mental Health (AMH) Services on their 18th birthday or referred to another community provider, dependent upon the individual’s needs. Individuals reaching 18 years of age who continue to need mental health services may be transferred to AMH services without meeting the adult priority population criteria and served for up to one additional year. Individuals who are 18 years of age or older and have previously received CMH services must be screened for AMH services using DSHS-approved UA.
- (3) For purposes of this contract definitions of “child” and “youth” are as follows:
 - (a) Child: An individual who is at least three years of age, but younger than 13 years of age.
 - (b) Youth: An individual who is at least 13 years of age, but younger than 18 years of age.
- d) Service Determination:
 - (1) In determining services and supports to be provided to the child/youth and family, the choice of and admission to medically necessary services and supports are determined jointly by the child/youth and family seeking services and supports and by Contractor;
 - (2) Criteria used to make these determinations are from the recommended LOC (LOC-R) of the individual as derived from the UA, the needs of the individual, Texas Resilience and Recovery Utilization Management Guidelines and the availability of resources;
 - (3) The Global Assessment of Functioning (GAF) is not used to determine eligibility for CMH services; and
 - (4) Children/Youth authorized for care by Contractor through a clinical override are eligible for the duration of the authorization. A clinical override for ineligible children/youth may not exceed a maximum of two consecutive authorizations.
- e) Continued Eligibility for Services:
 - (1) Reassessment by the provider and reauthorization of services by Contractor determines continued need for services. This activity is completed according to the UA protocols and Texas Resilience and Recovery Utilization Management Guidelines;
 - (2) Assignment of diagnosis in CARE is required at any time the Axis I diagnosis changes and at least annually from the last diagnosis entered into CARE; and
- f) The LPHA’s determination of diagnosis shall include an interview with the individual conducted either face-to-face or via tele-medicine/tele-health.
Documentation required:

In order to assign a diagnosis across all five axes to an individual, documentation of the required diagnostic criteria, as well as the specific justification of GAF score,

shall be included in the client record. This information shall be included as part of the required assessment information.

g) UA requirements

- (1) DSHS-approved UA for children and youth includes the following instruments:
 - (a) Child and Adolescent Needs and Strengths Assessment (CANS) ; and
 - (b) Community Data; and
 - (c) Authorized LOC
- (2) The above instruments are required to be completed once an individual has been screened and determined in need of assessment from Contractor. The initial assessment is the clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental or other information from the individual seeking services in order to determine specific treatment and support needs.
- (3) Staff administering the instruments shall be a QMHP-CS and have documented training in the use of the instruments; Staff administering the instruments must have documentation of current certification in the CANS or ANSA. Certification must be updated annually through a DSHS approved entity.
- (4) The UA shall be administered according to the timeframes delineated in Information Item C located at <http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm> Child Data Submission Requirements.

Contractor shall submit all required information in compliance with the schedule established by DSHS through either CARE/WebCare or Clinical Management for Behavioral Health Services System (CMBHS) as set forth in the following table:

| Required Submission | Approved Data Submission Methods | | | |
|---|--|-------------|---------------------|--------------------|
| | CMBHS Online(Use of the CMBHS web interface) | CMBHS Batch | CARE/WebCare Online | CARE/WebCare Batch |
| TTR Child Uniform Assessment using the Child and Adolescent Needs Assessment (CANS) | Yes | Yes | No | No |
| Assignments (Service, Activity & Destination) | No | No | Yes | Yes |
| Case Maintenance (Case delete, ID merge, ID split) | No | No | Yes | No |
| Client Profile (new and update) | Yes | No | Yes | Yes |
| Diagnosis | Yes | No | Yes | Yes |
| Follow up Contact | No | No | Yes | Yes |

| Required Submission | Approved Data Submission Methods | | | |
|--------------------------|--|-------------|---------------------|--------------------|
| | CMBHS Online(Use of the CMBHS web interface) | CMBHS Batch | CARE/WebCare Online | CARE/WebCare Batch |
| CARE County of Residence | No | No | Yes | No |
| Separations | No | No | Yes | No |
| Consent | Yes | No | N/A | N/A |

Contractor may only batch to CMBHS if Contractor has submitted Form U CMBHS Assessment Attestation regarding data exchange.

Contractor shall no longer enter, and DSHS will no longer accept, MH Uniform Assessment information through WebCare or the CARE System. MH Uniform Assessment data must be entered into CMBHS online or through a DSHS approved data exchange process.

3. Service Requirements

Contractor shall:

- a) Comply with UA requirements for children/youth in accordance with Section I.B.6. The UA is not required for individuals whose services are not funded with funds paid to Contractor under this Scope of Work.
- b) Children’s MH case managers can access and use <https://www.211texas.org/cms/> as required in Texas Government Code (TGC) §531.0244.
- c) Provide PFEP in accordance with the guidelines available from National Institute of Mental Health (NIMH) (located at <http://www.nimh.nih.gov/health/index.shtml>) or alternative guidelines approved by DSHS, on a schedule determined by DSHS. If children/youth and/ or their families and caregivers have not been educated about their diagnosis, the reason for the lack of education shall be documented in the clinical progress note.
- d) Apply TRR to all client services funded with contract funds in accordance with the following standards:
 - (1) Provide services in accordance with the most current version of DSHS’ Texas Resilience and Recovery Utilization Management Guidelines, Uniform Assessment which includes the Child and Adolescent Needs and Strengths (CANS), and Information Item V (for Crisis Services);
 - (2) Each child or youth for whom services are requested shall be screened to determine if they are part of the priority population and if services are warranted;
 - (3) Children and youth seeking services are assessed to determine if they meet the requirements of priority population and if so, a full assessment shall be conducted and documented using the most current version of the DSHS UA instruments, including the CANS. Individuals whose services are not funded with Scope of

- Work funds are exempt from inclusion in TRR regardless of priority population status;
- (4) Make available to each client recommended and authorized for a LOC, as indicated by the Uniform Assessment which includes the CANS all services and supports within the authorized LOC (LOC-A);
 - (a) A non-Medicaid eligible child or youth may not be deviated down more than one LOC without written documentation supporting clinical need for the deviation. If client and LAR refuse the entire level of care, the child or youth may not be deviated down more than one LOC without written documentation that the child or youth and LAR have received a detailed explanation of the increased risks that the child or youth may experience by not receiving the appropriate level of care and the impact that providing a lower level of care may have on the treatment outcomes and negative impact on the prognosis of the child or youth. LOC-4 may not be deviated down to LOC-1; and
 - (b) Medicaid-eligible children and youth may not have services denied, reduced, suspended, or terminated due to lack of available resources. If a Medicaid-eligible child, youth or the LAR of a child or youth refuses the recommended LOC, the child or youth may be served at the next most appropriate LOC as long as the services within that LOC are appropriate and medically necessary to address the child or youth's emotional disturbance. The LOC should not be reduced if the child, youth, or LAR refuses Family Partner services or family support groups only;
 - (5) Medicaid-eligible children and youth shall be provided with any medically necessary Medicaid-funded MH services within the recommended LOC without undue delay;
 - (6) Meet and require TRR services subcontractors to meet the training requirements for the DSHS-approved evidence-based practices prior to the provision of these services and supports as outlined in Information Item A. Completion of the training requirements shall be documented and maintained by Contractor and subcontractor.
 - (7) Wraparound Treatment Planning: This is a required component of Intensive Case Management and shall be implemented as outlined in 25 TAC Chapter 412, Subchapter I. Training requirements are outlined in Information Item A.
 - (8) Counseling: Counseling services shall be provided by an LPHA, practicing within the scope of a license, or when appropriate and not in conflict with billing requirements, by an individual with a master's degree in a human services field (e.g., psychology, social work, counseling) who is pursuing licensure under the direct supervision of an LPHA. Training and/or competency requirements are outlined in Information Item A. The allowable models of counseling and practice requirements are:
 - (a) Cognitive Behavioral Therapy (CBT): Providers of CBT must deliver the approved protocols as outlined in the Texas Resilience and Recovery Utilization Management Guidelines
 - (b) Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): TF-CBT is a required protocol. Contractor shall document completed training and clinical

consultations as outlined in Information Item A and according to UM Guidelines.

- (c) Parent-Child Psychotherapy (Dyad Therapy): This is an allowable model of counseling that may be delivered to children 3-5 years of age. To deliver this protocol, Contractor shall document completed training in one of the DSHS approved models of Parent-Child Psychotherapy as outlined in Information Item A.
- (9) Ensure that supervisors of services and supports within TRR are trained as trainers in the DSHS-approved evidence-based practices, are trained in the evidence-based practices, or have provided the evidence-based practices prior to the supervision of the evidence-based practices. Supervisors must complete this requirement within 180 days of assuming a supervisory position. If supervisors are unable to complete this requirement within 180 days of assuming the supervisory position, the LMHA must submit a plan to the department outlining how the supervisor will fulfill this requirement. Clinical supervisors for a QMHP-CS providing Skills Training and Development services must be at least a QMHP-CS.
- (10) Use the Uniform Assessment which includes the Child and Adolescent Needs and Strengths Assessment (CANS) to:
- (a) document the assessment of individuals seeking services;
 - (b) and to reassess current children/youth in services when update assessments are due or when service needs have changed to determine the recommended LOC for a child/youth;
- (11) Set aside Flexible Funds totaling \$1,500 per child for 10% of those children eligible to receive LOC 4. Use of Flexible Funds should occur in accordance with the Texas Resilience and Recovery Utilization Management Guidelines;
- (12) Hire or contract with a Certified Family Partner to provide peer mentoring and support to parents/primary caregivers of children and youth. Certified Family Partners hired or contracted must meet the following qualifications:
- (a) Is 18 years of age or older;
 - (b) Has received either:
 - i. A high school diploma; or
 - ii. A high school equivalency certificate issued in accordance with the laws applicable to the issuing agency;
 - (c) Has at least one year of lived experience raising a child or adolescent with an emotional or mental health issue as a parent or LAR;
 - (d) Has at least one year of experience navigating a child-serving system (e.g. mental health, juvenile justice, social security, or special education) as a parent or LAR; and
 - (e) Has the ability to perform the duties of a Family Partner as outlined in the Texas Resilience and Recovery Utilization Management Guidelines.
 - (f) Has successfully completed the certified Family Partner training and passed the certification exam recognized by the department within one year of the date of hire for the role of Family Partner.
- (13) Family Partner Supports are available in all LOCs, but Contractor shall serve a minimum of 54.90% of children and youth receiving services in LOC 4.

- (14) Ensure the Family Partner receives the appropriate training and supervision;
 - (15) Contractor shall serve individuals with funding allocated through Crisis Redesign for engagement, transition, and intensive ongoing services in accordance with Texas Resilience and Recovery Utilization Management Guidelines. CARE Report III shall be completed in accordance with Information Item D and submission timelines as outlined in Information Item S. Performance measures are outlined in Section II. G.;
 - (16) Contractor shall make family support groups available to the caregivers of children and youth with serious emotional disturbances; and
 - (17) Maintain access to CMBHS even if Contractor utilizes an approved batch process.
- e) Submit encounter data for all services according to the procedures, instructions, and schedule established by DSHS, including all required data fields and values in the current version of the DSHS Community Mental Health Service Array. The current version of DSHS Community Mental Health Service Array (i.e., Report Name: INFO Mental Health Service Array Combined) can be found in MBOW in the CA General Warehouse Information, Specifications subfolder.
- f) Comply with the following Medicaid-related requirements:
- (1) Contract with DSHS to be a provider for Medicaid MH Rehabilitative Services and Medicaid MH Case Management;
 - (2) Contract with HHSC to participate in Medicaid Administrative Claiming;
 - (3) Recognize that funding earned through billings to Texas Medicaid & Healthcare Partnership (TMHP) for Medicaid MH Case Management and Medicaid MH Rehabilitative Services represents the federal share and the State match; and
 - (4) Submit billing for the provision of Medicaid MH Case Management and Medicaid MH Rehabilitative Services to TMHP.
- g) Utilize non-contract funds and other funding sources (e.g., any person or entity who has the legal responsibility for paying all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other Federal, State, local, and private funding sources) whenever possible to maximize Contractor's financial resources. Contractor shall comply with the following requirements:
- (1) Enroll in the CHIP and bill CHIP for services covered under that plan;
 - (2) Become a Medicaid provider and bill Medicaid for services covered under that plan;
 - (3) Provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs;
 - (4) Allow clients that are otherwise eligible for DSHS services, but that cannot pay a deductible required by a third party payor, to receive services up to the amount of the deductible and to use DSHS funds to pay for the deductible;
 - (5) Maintain appropriate documentation from the third party payor reflecting attempts to obtain reimbursement;
 - (6) Bill all other funding sources for services provided under this Scope of Work before submitting any request for reimbursement to DSHS; and

- (7) Provide all billing functions at no cost to the client.
- h) Expend TANF transfer to Title XX Social Services Block grant (SSBG) funds to provide comprehensive community MH services to clients with serious emotional disturbance. Contractor shall utilize the SSBG under 42 USC §1397 (also known as Title XX of the Social Security Act) for the provision of the following services to clients in the priority population and report this information on Form L.
- (1) Case management services, which are services or activities for the arrangement, coordination, and monitoring of services to meet the needs of individuals and families. Component services and activities may include individual service plan development, counseling, monitoring, developing, securing, and coordinating services; monitoring and evaluating client progress; and assuring that clients' rights are protected. This service includes Routine Case Management, Intensive Case Management and Family Case Management as defined in Information item G of the Performance Contract.
 - (2) Education and Training Services, which are those services provided to improve knowledge or daily living skills and to enhance cultural opportunities. Services may include, but are not limited to, instruction or training in such issues as consumer education, health education, community protection and safety education, literacy education, English as a second language, and General Educational Development (G.E.D.). Component services or activities may include, but are not limited to, screening, assessment and testing; individual or group instruction; tutoring; provision of books, supplies and instructional material; counseling; transportation; and referral to community resources. This service includes Skills Training and Development Services as defined in Information Item G of the Performance Contract.
 - (3) Counseling services, which are services or activities that apply therapeutic processes to personal, family and situational problems in order to bring about a positive resolution of the problem and improve individual and family functioning or circumstances. Problem areas may include:
 - (a) Family relationships;
 - (b) Parent-child problems;
 - (c) Depression;
 - (d) Child abuse;
 - (e) Anxiety;
 - (f) Trauma responses, child traumatic stress or Post-Traumatic Stress Disorder, or
 - (g) Drug abuse when in conjunction with a serious emotional disturbance. This service includes Counseling as defined in Information item G of the Performance Contract.
 - (4) Health related and home health services are those in-home or out-of- home services or activities designed to assist individuals and families to attain and maintain a favorable condition of health. Component services and activities may include providing an analysis or assessment of an individual's health problems and the development of a treatment plan; assisting individuals to identify and understand their health needs; assisting individuals to locate, provide or secure, and utilize appropriate medical treatment, preventive medical care, and health

maintenance services, including in-home health services and emergency medical services; and providing follow-up services as needed.

This service includes Pharmacological Management as defined in Information Item G of the Performance Contract.

- (5) Special services for clients involved or at risk of involvement with criminal activity, which are those services or activities for clients who are, or who may become, involved with the juvenile justice system. Component services or activities are designed to enhance family functioning and modify the client's behavior with the goal of developing socially appropriate behavior and may include counseling, intervention therapy, and residential and medical services if included as an integral but subordinate part of the service. This service includes Skills Training and Family Trainings as defined in Information Item G of the Performance Contract.
- (6) Other services meeting the requirement of TANF transfer to Title XX as approved by the Department.
 - i) Provide services to all clients without regard to the client's history of arrest, charge, fine, indictment, incarceration, sentence, conviction, probation, deferred adjudication, or community supervision for a criminal offense.
 - j) Develop and implement written procedures to identify clients and to ensure continuity of screening, assessment, and treatment services provided to individuals with Co-Occurring Psychiatric and Substance Use Disorders (COPSD), in accordance with 25 TAC, part 1, chapter 411, Subchapter N, Contractor shall ensure both mental health and substance use needs are being concurrently addressed. Contractor shall for continuity of care purposes:
 - (1) identify available resources (internal and external),
 - (2) provide referrals and referral follow-up for ongoing services as clinically indicated to address the client's substance use needs while receiving mental health services and document in the electronic health record.
 - (3) Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications.
 - k) Conduct all initial and on-going diagnostic assessments face-to-face or by tele-medicine/tele-health with the individual to determine priority population eligibility.
 - (1) If a child is placed in a DSHS-funded residential treatment center (RTC) bed (excluding the Waco Center for Youth) outside of the LMHA service area, ongoing diagnostic assessments may be provided by phone, utilizing data collected from the child, child's LAR, and child's RTC therapist.
 - l) Implement crisis services in compliance with the standards outlined in Information Item V.

SECTION II. SERVICE TARGETS, OUTCOMES, AND PERFORMANCE MEASURES

Contractor shall meet the service targets, performance measures, and outcomes outlined below. Remedies and Sanctions associated with these service targets, performance measures, outcomes will be imposed in accordance with the terms included in this Scope of Work or Article VII. of the Local Mental Health Authority Special Conditions.

A. Adult Services

Adult service performance measures shall be assessed 37 calendar days following the close of the second and fourth quarters. Detailed information pertaining to calculations and data sources can be found in Information Item C at:

<http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>.

1. Adult Service Target

- a) Target: 10,348 The total number of clients authorized in a full level of care (FLOC). Targets will be reviewed semi-annually.

- b) Sanctions: Recoupment will be waived for the first two quarters of the fiscal year. For quarters three and four, recoupment will be assessed based on the total number served in the fourth quarter of fiscal year 2016. Recoupments associated with this Target are the following:
 - (1) If the total number served is greater than or equal to 100%, there is no recoupment;
 - (2) If the total number served is 95% to 99% of the target and there are no adults waiting for all services, there is no recoupment;
 - (3) If the total number served is 95% to 99% of the target and there are adults waiting for all services, the recoupment is 1.4% of Contractor's current two quarters' funding for adult MH services;
 - (4) If the total number served is 90% to 94% of the target the recoupment is 1.4% of Contractor's current two quarters' funding for adult MH services;
 - (5) If the total number served is 85% to 89%, the recoupment is 2.8% of Contractor's current two quarters' funding for adult MH services ;
 - (6) If the total number served is 80% to 84%, the recoupment is 5.6% of Contractor's current two quarters' funding for adult MH services ;
 - (7) If the total number served is 75% to 79%, the recoupment is 11.2% of Contractor's current two quarters' funding for adult MH services ; and
 - (8) If the total number served is <75%, the recoupment is 22% of Contractor's current two quarters' funding for adult MH services , in addition to other remedies and sanctions specified in Article VII of the Local Mental Health Authority Special Conditions.

NOTE: LMHAs may contact their assigned contract manager to notify DSHS of any potential impact on the LMHA's ability to meet contractual requirements resulting from a significant change in local or other funding used to serve adults in the priority population. If DSHS agrees the change in funding is potentially significant, DSHS will provide an estimate of the total number to be served based on the information provided. At the end of the year, DSHS will waive recoupment for LMHAs with a significant change in funding if the total expenditure of funds is less than \$4,150 per adult served. The calculation for this determination will be: Strategy B.2.1, Mental

Health Services-Adults Quarter 4 CARE Report III Preliminary Line 800 / Adult Average Monthly Served for the reporting period. When CARE Report III is final, DSHS will adjust the LMHA's target if the funding per target is less than \$4,150. The calculation for this determination will be: Strategy B.2.1, Mental Health Services-Adults Quarter 4 CARE Report III Final Line 800 / Adult Service Target.

2. Adult Uniform Assessment (UA) Completion Rate
 - a) Target: The percentage of adults served or authorized for services during the six month period with a completed and current Uniform Assessment (UA) will be $\geq 95\%$. Targets will be reviewed semi-annually.
 - b) Sanctions Associated with this Measure are the following:
 - (1) If Contractor achieves greater than or equal to 95%, there is no recoupment;
 - (2) If Contractor achieves from 85% to 94%, the recoupment is 1.4% of Contractor's current two quarters' funding for adult MH services;
 - (3) If Contractor achieves from 75% to 84%, the recoupment is 2.8% of Contractor's current two quarters' funding for adult MH services;
 - (4) If Contractor achieves from 65% to 74%, the recoupment is 5.6% of Contractor's current two quarters' funding for adult MH services; and
 - (5) If Contractor achieves less than 65%, the recoupment is 11.2% of Contractor's current two quarters' funding for adult MH services.
3. Adult Targets – Counseling and ACT.
Measured Semi-Annually.
 - a) The monthly average of all adults authorized into LOC-2 is greater than or equal to 12% of adults recommended for LOC-2.
 - b) The monthly average of all adults recommended for LOC-4 and authorized into LOC-3 or LOC-4 is greater than or equal to 54.0%.
4. Resilience and Recovery Outcomes – Adult Mental Health Services
Adult service outcomes shall be measured 37 calendar days following the close of Quarter 2 (measuring Quarter 1 and 2) and Quarter 4 (Measuring Quarter 3 and Quarter 4). For each outcome target met, Contractor will receive a percentage of withheld general revenue allocation in proportion to the number of outcome targets met. For each individual outcome measure met, Contractor may be eligible for redistribution of general revenue funds that are withheld from Centers that did not meet outcome targets.
 - a) Employment. - The percentage of adults in a full LOC who have independent employment shall be 9.8% per measurement period.
 - b) Adult Community Tenure. - The percentage of adults in a full LOC that avoid hospitalization in a DSHS purchased inpatient bed shall be $\geq 96.4\%$ per measurement period.

- c) Adult Improvement. - The percentage of adult population showing reliable improvement in one or more ANSA domains/modules shall be $\geq 20.0\%$ per measurement period.
- d) Adult Monthly Service Provision. - The percentage of individuals authorized in a full LOC receiving at least one face-to-face, telehealth or telemedicine encounter of any service per month of any length of time shall be $\geq 65.6\%$. FLOCs included in this measure are LOC-1S, LOC-2, LOC-3, and LOC-4. LOC-1M is excluded from this measure. Additionally, individuals who are both recommended and authorized for LOC-A1S are excluded from this measure. Encounters must be delivered face-to-face or via telehealth or telemedicine.

FY16 will serve as a benchmarking year for the following Resilience and Recovery Outcomes. There will be no sanctions assessed for these outcomes during the FY16 benchmarking year:

- e) Employment- The percentage of adults authorized in a FLOC with acceptable or improved employment performance.
 - f) Residential Stability - The percentage of adults authorized in a FLOC with acceptable or improved residential stability.
 - g) Strengths - The percentage of adults authorized in a FLOC with acceptable or improved strengths.
 - h) Life Domain Functioning - The percentage of adults authorized in a FLOC with acceptable or improved life functioning.
 - i) Educational or Volunteering Strengths - The percentage of adults authorized in a FLOC with acceptable or improved employment-preparatory skills as evidenced by Educational or Volunteering Strengths.
5. Resilience and Recovery Crisis Outcomes – Applicable for Adult and Children’s Mental Health Services
- Crisis service outcomes for adults and children shall be measured 37 calendar days following the close of Quarter 2 (measuring Quarter 1 and Quarter 2) and Quarter 4 (Measuring Quarter 3 and Quarter 4). For each outcome target met, Contractor will receive a percentage of withheld general revenue allocation in proportion to the number of outcome targets met. For each individual outcome measure met, Contractor may be eligible for redistribution of general revenue funds that are withheld from centers that did not meet outcome targets.
- a) Hospitalization. - The equity-adjusted rate of DSHS Operated or Contracted Inpatient bed-days in the population of the local service area shall be $\leq 1.9\%$ per measurement period.

- b) Effective Crisis Response. - The percentage of adults and children/youth who receive crisis services and avoid DSHS Operated or Contracted Inpatient bed within 30 days of the first day of the crisis episode shall be $\geq 75.1\%$ per measurement period.
 - c) Frequent Admissions. -The percentage of adults and children/youth in a FLOC admitted three or more times to a DSHS Operated or Contracted Inpatient bed within 180 days shall be $\leq 0.3\%$ per measurement period.
 - d) Access to Crisis Response Services. -The percentage of crisis hotline calls that result in face-to-face encounters shall be $\geq 52.2\%$ per measurement period.
 - e) Adult Jail Diversion. – The equity-adjusted percentage of valid Texas Law Enforcement Telecommunications System (TLETS) bookings across the adult population with a match in CARE shall be $\leq 10.46\%$.
6. TANF transfer to Title XX and Base Title XX
Adults served with TANF transfer to Title XX and Base Title XX funds.

Fiscal Year Target: Expected targets are listed in Information Item C.

B. Child and Youth Services

Children’s service performance measures shall be assessed 37 calendar days following the close of the second and fourth quarters. Detailed information pertaining to calculations and data sources can be found in Information Item C at

<http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>.

1. Child and Youth Service Target

Target: 2,719 The total number of clients authorized in a FLOC and LOC-Y (Youth Empowerment Services). DSHS will review targets semi-annually.

- a) Sanctions: Recoupment will be waived for the first two quarters of the fiscal year. For quarters three and four, recoupment will be assessed based on the total number served in the fourth quarter of fiscal year 2016. Recoupments associated with this Target are the following:
 - (1) If the total number served is greater than or equal to 100%, there is no recoupment;
 - (2) If the total number served is 95% to 99% of the target and there are no children waiting for all services, there is no recoupment;
 - (3) If the total number served is 95% to 99% of the target and there are children waiting for all services, the recoupment is 1.4% of Contractor’s current two quarters’ funding for children’s MH services;
 - (4) If the total number served is 90% to 94% of the target the recoupment is 1.4% of Contractor’s current two quarters’ funding for children’s MH services;
 - (5) If the total number served is 85% to 89%, the recoupment is 2.8% of Contractor’s current 2 quarters funding for children’s MH services;
 - (6) If the total number served is 80% to 84%, the recoupment is 5.6% of Contractor’s current 2 quarters funding for children’s MH services;

- (7) If the total number served is 75% to 79%, the recoupment is 11.2% of Contractor's current 2 quarters funding for children's MH services; and
- (8) If the total number served is <75%, the recoupment is 22% of Contractor's current 2 quarters funding for children's MH services.

NOTE: LMHAs may contact their assigned contract manager to notify DSHS of any potential impact on the LMHA's ability to meet contractual requirements resulting from a significant change in local or other funding used to serve adults in the priority population. If DSHS agrees the change in funding is potentially significant, DSHS will provide an estimate of the total number to be served based on the information provided. At the end of the year, DSHS will waive recoupment for LMHAs with a significant change in funding if the total expenditure of funds is less than \$4,000 per child served. The calculation for this determination will be: Strategy B.2.2, Mental Health Services-Children Quarter 4 CARE Report III Preliminary Line 800 / Child and Youth Average Monthly Served for the reporting period. When CARE Report III is final, DSHS will adjust the LMHA's target if the funding per target is less than \$4,000. The calculation for this determination will be: Strategy B.2.2, Mental Health Services-Children Quarter 4 CARE Report III Final Line 800 / Child and Youth Service Target.

2. Child and Youth Uniform Assessment (UA) Completion Rate

- a) Target: The percentage of children and youth served or authorized for services during the six month period who have a completed and current UA will be $\geq 95\%$. DSHS will review targets semi-annually.
- b) Sanctions Associated with this Measure are the following:
 - (1) If Contractor achieves greater than or equal to 95%, there is no recoupment;
 - (2) If Contractor achieves from 85% to 94%, the recoupment is 1.4% of Contractor's current two quarters' funding for children's MH services
 - (3) If Contractor achieves from 75% to 84%, the recoupment is 2.8% of Contractor's current two quarters' funding for children's MH services;
 - (4) If Contractor achieves from 65% to 74%, the recoupment is 5.6% of Contractor's current two quarters' funding for children's MH services;
 - (5) If Contractor achieves less than 65%, the recoupment is 11.2% of Contractor's current two quarters' funding for children's MH services.

3. Family Partner Support Services

- a) Target: 10% or more of children and youth authorized to receive LOC 2, 3, 4 and YC shall receive Family Partner support services each client month. See Information Item C glossary for a description of Family Partner support services.
- b) Sanctions Associated with this Measure do not apply to the first quarter. Following the first quarter, the following sanctions apply:
 - (1) If Contractor achieves greater than or equal to 10%, there is no recoupment;
 - (2) If Contractor achieves from 5% to 9%, the recoupment is 0.15 % of Contractors current two quarters' funding for children's MH services;
 - (3) If Contractor achieves from 0% to 4%, the recoupment is 0.3% of Contractor's

current two quarters' funding for children's MH services.

4. Resilience and Recovery Outcomes

Children's service outcomes shall be measured 37 calendar days following the close of Quarter 2 (measuring Quarter 1 and Quarter 2) and Quarter 4 (Measuring Quarter 3 and Quarter 4). For each outcome target met, Contractor will receive a percentage of withheld general revenue allocation in proportion to the number of outcome targets met. For each individual outcome measure met, Contractor may be eligible for redistribution of general revenue funds that are withheld from Centers that did not meet outcome targets.

- a) Juvenile Justice Avoidance. – The percentage of all children/youth enrolled in a FLOC showing no arrests (acceptable) or a reduction of arrests (improving) from time of first assessment to time of last assessment shall be $\geq 95.0\%$ within the measurement period.
- b) Child and Youth Community Tenure. –The percentage of all children/youth in a FLOC avoiding psychiatric hospitalization in a DSHS purchased bed after authorization into a FLOC shall be $\geq 98.1\%$.
- c) Child and Youth Improvement. – The percentage of children/adolescent population showing reliable improvement in one or more CANS domains/modules shall be $\geq 25.0\%$ per measurement period.
- d) Child and Youth Monthly Service Provision. Target – The percentage of individuals authorized in a full LOC receiving at least one face-to-face, telehealth or telemedicine encounter of any service per month of any length of time shall be $\geq 65\%$ per measurement period.

FY16 will serve as a benchmarking year for the following Resilience and Recovery Outcomes. There will be no sanctions assessed for these outcomes during the FY16 benchmarking year:

- e) School - The percentage of children and youth authorized in a FLOC with acceptable or improved school performance.
 - f) Living and Family Situation - The percentage of children and youth authorized in a FLOC with acceptable or improved family and living situations
 - g) Strengths - The percentage of children and youth authorized in a FLOC with acceptable or improved strengths.
 - h) Life Domain Functioning - The percentage of children and youth authorized in a FLOC with acceptable or improved life functioning.
5. TANF transfer to Title XX
Children served with TANF transfer to Title XX funds.

Fiscal Year Target: Expected targets are listed in Information Item C.

C. Community Support Plan

Information pertaining to calculations and data sources is in Information Item C at <http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>. This outcome shall be assessed quarterly in accordance with Information Item S – Quarterly CARE Data Reports.

The percentage of adults and children/youth discharged from state facilities with a community support plan is assessed quarterly as follows:

1. The number of adults and children/youth discharged from state MH campus-based facilities (state hospital, state center) to Contractor that have a community support plan.
2. Target: Shall not be less than 95%.

D. Follow-Up Within Seven Days

Information pertaining to calculations and data sources is in Information Item C at <http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>. These outcomes shall be assessed quarterly in accordance with Information Item S – Quarterly CARE Data Reports.

1. Follow-up within seven days:
 - a) Face-to-face follow-up contacts with individuals discharged from a state facility, privately operated and state funded facility (i.e., Montgomery County Mental Health Treatment Facility and University of Texas Health Science Center at Tyler), or private psychiatric hospital funded through a Private Psychiatric Bed (PPB) or Community Mental Health Hospital (CMHH) contract within seven days are greater than or equal to 75%; and
 - b) Follow-up disposition of individuals discharged from a state facility, privately operated and state funded facility (i.e., Montgomery County Mental Health Treatment Facility and University of Texas Health Science Center at Tyler), or private psychiatric hospital funded through a Private Psychiatric Bed (PPB) or Community Mental Health Hospital (CMHH) contract within seven days is greater than or equal to 95%.

E. Long Term Services and Support

Contractor shall act upon referrals within 15 calendar days of receipt from the Long-term Services and Supports (LTSS) Screen. Contractor shall demonstrate successful action on a referral by utilizing the H0023 procedure code (grid code 100) for adults and the H0023HA procedure code (grid code 200) for children.

F. Crisis Response System Outcome Measures

Crisis response system outcomes shall be measured 37 calendar days following the close of the fourth quarter. Contractor shall not be subject to sanctions and remedies for each

outcome minimum achieved.

1. Community Linkage

No less than 23% of adults, children, and youth with a mental health community LOC-A = 0 will be followed by a mental health community LOC-A = 1 - 5, and/or a service contact at a DSHS-funded substance abuse treatment facility, or at an Outreach, Screening, Assessment and Referral (OSAR) provider within 14 days after the crisis episode.

2. Crisis Follow Up

No less than 90% of adults, children, and youth with a mental health community LOC-A = 5 have a crisis follow-up service encounter within 30 days of the LOC-A = 5.

G. YES Waiver Requirements

1. Contractor must enroll and serve in the YES Waiver a minimum average of: 123 clients.

2. An enrolled and served client is defined as a client with a submitted and approved Initial IPC in place on the performance measure assessment date in accordance with the schedule and methodology (Section II.A).

3. Contractor shall submit IPCs in accordance with the YES Waiver Policy and Procedure Manual.

4. Contractor shall continue to assess and, if found to be eligible, enroll clients in excess of their minimum enrollment requirement in accordance with Inquiry List Management policies (Section I.B).

5. Contractor shall not maintain a wait list for YES Waiver enrollment.

6. Achievement of minimum enrollment requirements will be determined according to the following schedule and methodology: Implementation Date can be found at <http://www.dshs.state.tx.us/mhsa/yes/>

a) Contractor shall enroll and serve 45% of their YES Waiver minimum enrollment requirement on or before the sixth month of implementation.

(1) If the total number of clients enrolled does not reach 45% or greater of Contractor's YES Waiver minimum enrollment on or before the sixth month, Contractor shall be subject to a sanction in the amount of \$3,000.00.

b) Contractor shall enroll 85% of their YES Waiver minimum enrollment requirement on or before the twelfth month of implementation.

(1) If the total number of clients enrolled does not reach 85% or greater of Contractor's YES Waiver minimum enrollment on or before the twelfth month, Contractor shall be subject to a sanction in the amount of \$3,000.00.

- c) Contractor shall enroll 100% of their YES Waiver minimum enrollment requirement on or before the eighteenth month of implementation.
 - (1) If the total number of clients enrolled does not reach 100% or greater of Contractor's YES Waiver minimum enrollment requirement on or before the eighteenth month, Contractor shall be subject to a sanction in the amount of \$3,000.00.
 - d) Contractor shall maintain their YES Waiver minimum average enrollment requirement beginning the nineteenth month of implementation.
 - (1) Contractor's average enrollment will be calculated by adding the number of unique individuals enrolled each month in a reporting period and dividing that number by the number of months in the reporting period.
 - (2) If the average enrollment does not reach 100% or greater of Contractor's YES Waiver minimum average enrollment requirement after the nineteenth month, Contractor shall be subject to a sanction in the amount of \$3,000.00.
7. All YES Waiver participants served will count toward overall Children's Services targets in accordance with Section II.B.1 of the PCN except where clients over the age of 18 are authorized into an Adult Level of Care. The decision to authorize clients over the age of 18 into an Adult Level of Care is made at the local level. YES Waiver participants authorized into an Adult Level of Care will count toward overall Adult Services targets in accordance with Section II.A.1 of the PCN.
 8. Inquiry List Management: Contractor shall submit a complete and up to date Inquiry List to DSHS on the last business day of each month.
 9. Contractor shall maintain documentation of the services outlined in Section I and shall provide DSHS with documentation of compliance with policies in the YES Waiver Policy and Procedure Manual within five business days of a request from DSHS.
 10. Transition Plan Development and Coordination:
Contractor shall assist the participant in the development of a transition plan and submit the plan to DSHS for review and approval at least six months before the participant's 19th birthday.
 11. Quality Management
 - a) Contractor shall implement and maintain its DSHS-approved YES Waiver Specific Quality Management plan which includes activities intended to monitor compliance with all YES Waiver policies and procedures as outlined in the YES Waiver Policy Manual and address any necessary corrective actions identified during Quality Management reviews. The YES Waiver Specific Quality Management Plan may be a part of the larger agency wide plan if it addresses YES specific activities.

- b) Contractor shall perform all activities outlined in the approved Quality Management plan.
- c) The Quality Management Plan must be submitted by March 31st of each fiscal year for DSHS approval or upon request by DSHS YES Program staff.

12. Wraparound Facilitation

- a) Contractor shall utilize the Medicaid Intensive Case Management (ICM) service to coordinate client enrollment and service provision and to develop client plans of care.
- b) ICM shall be delivered utilizing the National Wraparound Implementation (NWIC) model.
- c) Direct service providers of ICM shall meet training requirements outlined in Information Item A as applicable to Training Requirements for the provision of ICM.
- d) Intensive Case Manager Caseload Maximums:
 - (1) On or before the sixth month of implementation: direct service providers of ICM shall maintain a caseload size no greater than 15 clients;
 - (2) On or before the twelfth month of implementation: direct service providers of ICM shall maintain a caseload size no greater than 12 clients;
 - (3) On or before the eighteenth month of implementation: direct service providers of ICM shall maintain a caseload size no greater than 10 clients;
 - (4) Exceptions: Contractor must request and submit a plan to DSHS for approval for blended caseloads if direct service providers of ICM provide other services.

SECTION III. SERVICE AREA

Counties:

SECTION IV. PAYMENT METHOD

Quarterly Allocation

SECTION V: BUDGET

Source of Funds: State and Federal